BRITISH COLUMBIA

Patient Care Quality Review Boards

Annual Report 2015/2016

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Letter to the Minister of Health

December 5, 2016

The Honourable Terry Lake
Minister of Health
Room 337, Parliament Buildings
Victoria, BC V8V 1X4

Dear Minister,

It is our pleasure to present the Patient Care Quality Review Boards' Annual Report for the period from April 1, 2015 to March 31, 2016. This report has been prepared in accordance with sections 15(1) and 16(1) of the Patient Care Quality Review Board Act.

The Patient Care Quality Review Boards provide patients with a confidential means to address concerns they may have about their care experiences within our health-care system and to ensure a fair and independent review of these concerns. This is a detailed and demanding process that aims to resolve patient complaints, as well as bring opportunities for care quality improvements to the attention of the Ministry of Health and health authorities. For the review process to be effective, it is dependent upon the co-operation of the Ministry of Health, the Patient Care Quality Offices in the health authorities and the front-line staff throughout the province. In addition, these opportunities for care quality improvement would not be possible without those patients, clients, residents, and their loved ones who bring their personal health-care experiences to us.

The chairs of the six Patient Care Quality Review Boards would like to take this opportunity to acknowledge the difficult but rewarding job of our secretariat staff. Their expertise and commitment is critical to the overall success of this program.

Respectfully submitted,

Dr. John (Jack) H. Chritchley
chair, Vancouver Coastal/Provincial Health Services Patient Care Quality Review Boards

William Norton
chair, Northern Patient Care Quality Review Board

Thomas Humphries
chair, Interior Patient Care Quality Review Board

Richard J. Swift, Q.C.
chair, Vancouver Island Patient Care Quality Review Board

Hanne Madsen
chair, Fraser Patient Care Quality Review Board

Patient Care Quality Office

"In this era of patient centred and patient led health care, it is critical that we deliver an effective mechanism for the patient's voice and the patient's experience to address improvements in care quality throughout all aspects of our complex system of health care."

JOHN (JACK) H. CHRITCHLEY
chair, Vancouver Coastal/ Provincial Health Services Patient Care Quality Review Boards

Introduction

The Patient Care Quality Review Boards were established by the Patient Care Quality Review Board Act in 2008 to provide a clear, consistent, timely and transparent approach to managing patient care quality complaints in British Columbia. There are six boards – each aligned with a health authority. The boards are independent from the health authorities and are accountable to the Minister of Health.

The health system in British Columbia is large and complex and provides a huge number of health-care interventions each year, and is expected to respond to patient concerns and formal complaints.

In the event a patient, a loved one or representative has a complaint about the quality of a health-care service received (or expected and not received), they are encouraged to raise that concern at the time and place the care is being provided (or should be provided). If this does not address their concerns, they may make a formal complaint to the health authority's Patient Care Quality Office. If they continue to remain unsatisfied with how their complaint was handled following the Patient Care Quality Office's investigation, they may then bring their complaint to the board for review.

In order to conduct an effective review of a complaint, the Patient Care Quality Review Boards Secretariat provides the board members with a complete understanding of a patient's experience as it relates to the complaint. This may include, but is not limited to, an overview of the complaint and the complainant's concerns and experiences, complete medical records, guidelines and policies, as well as the investigation and response by the health authority. This allows the board to conduct a comprehensive review of the complaint as it relates to the care experiences. The board is then, when necessary, able to recommend areas of improvement to the health authority or to the Minister of Health to improve processes, policies or services. The boards view each complaint as a potential opportunity to improve the quality of care within our health-care system.

The Patient Care Quality Review Boards' annual report provides an overview of the care quality concerns brought forward to the boards for review, and illustrates where recommendations by the board have made improvements to our health-care system for the benefit of all British Columbians.

Executive Summary

Since the program's inception in 2008, the boards have completed 555 reviews, and made 692 recommendations to the health authorities and 16 recommendations to the Minister of Health. The boards may make multiple recommendations in one case.

In 2015/16, the boards accepted 111 review requests – representing the highest annual intake. The boards completed 97 reviews and made 101 recommendations to the health authorities and five recommendations to the Minister of Health.

Some key themes arising from this year's board recommendations to the health authorities centred on communication during end-of-life care, surgical services and health care in rural settings. Of the five recommendations made by the board to the Minister of Health, two centered on improving the investigation of care quality complaints in licensed residential care facilities.

In 2015/16, the boards did not make recommendations in 43 of the cases because either the care quality provided was assessed as appropriate or the circumstances of the complaint did not present an opportunity for care quality improvement.

The boards also track data about the types and number of client exchanges it directly receives. In total, the boards received 554 client enquiries relating to a broad range of care quality issues. This includes all other inquiries (by telephone, fax, email or letter) in addition to the formal review requests.

Similarly, the health authorities' Patient Care Quality Offices also collect data regarding the number and types of complaints and inquiries (e.g., requests for information) they receive. This data is reported quarterly to the boards.

This year, the offices received 7,133 complaints concerning care quality, which was only slightly more than the 7,107 care quality complaints received last year. Of the more than 7,000 complaints received by the health authorities, 111 of those complainants submitted a request for a review to the boards.

> *"In delivering health services, quality is not always measurable objectively. If the patient doesn't believe that they have had appropriate treatment, then that is worthy of a critical review, and that is our role."*
>
> **RICHARD J. SWIFT**
> *chair, Vancouver Island Patient Care Quality Review Board*

Care Quality Improvements and Board Achievements

The boards reached a milestone this year, completing their 500th review. That total proceeded to grow to 555 by the end of the fiscal year. It is evidence that the boards have provided a valuable avenue for patients, clients, residents and their families to raise complaints about their health care. By building upon the patient experience here in British Columbia, the Patient Care Quality Review Boards have contributed to significant positive change and improvement in our health-care system. The boards take this opportunity to thank all those who made the effort and took the time to raise their concerns so that improvements could be made.

The boards' recommendations to the health authorities and Minister of Health are based on the boards' review of the facts about the case presented to them. Once a recommendation is received, the health authority or Minister of Health is required to respond with its plan to address the recommendation or to indicate whether work is already underway to address the recommendation. The responses to the boards' recommendations have the potential to lead to better outcomes and care quality improvement in the health-care system.

In previous years, complaints related to the Vancouver Coastal, Fraser and Provincial Health Services boards were reviewed by the same board chair and members. In light of the increasing work load on those members, the Minister of Health made a decision to create a new separate membership for the Fraser board. As a result, the Fraser board is now served by a newly appointed chair and members separate from the Vancouver Coastal and Provincial Health Services board. This has improved timeliness of reviews, reduced the burden of work on members, and allowed the boards to gain a wealth of knowledge and experience from new members. New members were also appointed by the Minister of Health to each of the other five boards in 2015, the single largest change in board membership since 2008.

As the common administrative body for the boards, the Patient Care Quality Review Boards Secretariat introduced an updated case management system. This system was developed to support the unique needs of the boards, and provides improved access, tracking, and reporting of case files. The boards acknowledge the secretariat's ongoing efforts to strive for continued improvements.

The boards would also like to take the opportunity to acknowledge the work of the Patient Care Quality Offices and their officers. Their ongoing efforts in striving for care quality improvements in our health system are commendable.

Key Recommendation Themes in 2015/16

Communication during end-of-life care

While communication with patients and their loved ones is always an important part of patient-centered care, communication with a patient's loved ones is especially important during end-of-life care. Emotions are heightened when a loved one is sick and many individuals have a hard time coming to terms with the reality of the seriousness of an illness. Clear, empathetic and regular communication while a patient is in care helps loved ones better cope and understand the serious nature of a patient's illness and the likelihood they may pass away. Following the death of a patient, loved ones may have trouble accepting the death, especially in cases where the death was unexpected, and empathetic communication is vital in allowing loved ones to grieve and come to terms with the death. As a result, the boards made multiple recommendations related to communication with loved ones both while a patient was in care and after their death.

Surgical Services

Before receiving a surgery, there are a number of steps that must be taken, including testing, diagnosis, surgical consultations, options for different types of surgery, as well as booking and scheduling of the determined procedure. These steps play as vital a role in patient-centred care as the surgical procedure itself, and the boards made a number of recommendations to improve this process. Recommendations included improved charting to make sure the correct procedure is booked in a timely manner, increased written communication with patients about the booking process, and increased information regarding complications post-surgery and what to do if they happen.

Rural Settings

Rural settings create unique challenges when it comes to providing quality health care as they do not have the same range of services available as urban settings. Over the past two years, the boards made a number of recommendations to improve health-care services in rural settings. Recommendations included providing training to medical staff on when it is appropriate to transfer patients to larger medical centres for more specialized care, as well as the logistics and timeliness surrounding that transfer.

> *"Our diverse boards are made up of talented and committed individuals who are genuinely invested in providing recommendations to the health authorities and Ministry of Health to improve the health-care system in British Columbia."*
>
> **HANNE MADSEN**
> *chair, Fraser Patient Care Quality Review Board*

About the Patient Care Quality Review Boards

> *"Reviewers for each B.C. health region have an opportunity to witness the extraordinary scope of health services delivered hour by hour and day by day across their health region. Not only is the range of services very broad, but the population and geography is also vast. Further, all aspects of health care knowledge are evolving quickly. In this rapidly changing system, the boards are empowered to analyse the quality of care experienced by a patient and to make recommendations regarding improvements to patient care."*
>
> **THOMAS HUMPHRIES**
> *chair, Interior Patient Care Quality Review Board*

Mandate

The *Patient Care Quality Review Board Act* and External Complaint Regulation govern how the boards review complaints and what can and cannot be reviewed.

The boards may review any care quality complaint regarding services funded or provided by a health authority, either directly or through a contracted agency. The boards may also review complaints regarding services expected, but not delivered, by a health authority (e.g., a complaint regarding a cancelled surgery).

The boards may only review complaints that have first been addressed by a health authority's Patient Care Quality Office, unless otherwise directed by the minister.

If the boards receive a complaint that cannot be reviewed, the complainant is redirected to the most appropriate body for their concerns.

As a result of a review, the boards can make recommendations to a health authority or to the minister to improve the way complaints are handled, to improve the quality of patient care, or to resolve a specific care quality complaint.

Finally, the boards monitor, track, and report on care quality complaints in British Columbia.

The Review Process

Patients or their representatives may request a review by submitting a review request form (by mail, email, online or fax) or by calling 1 866 952-2448. If the board receives a review request, the health authority's Patient Care Quality Office will be notified and asked to provide a copy of any information relating to the complaint.

The board will review the facts and other background information, seeking expert advice and/or clarification from the health authority, the complainant, and/or other experts, as required.

Once the review is complete, the board will send the complainant and the health authority a final decision letter, indicating whether any recommendations have been made. The board explains its findings and the reasoning for decisions in the letter. A copy of the letter is also sent to the Minister of Health so the ministry can follow up with the health authority on the implementation of recommendations.

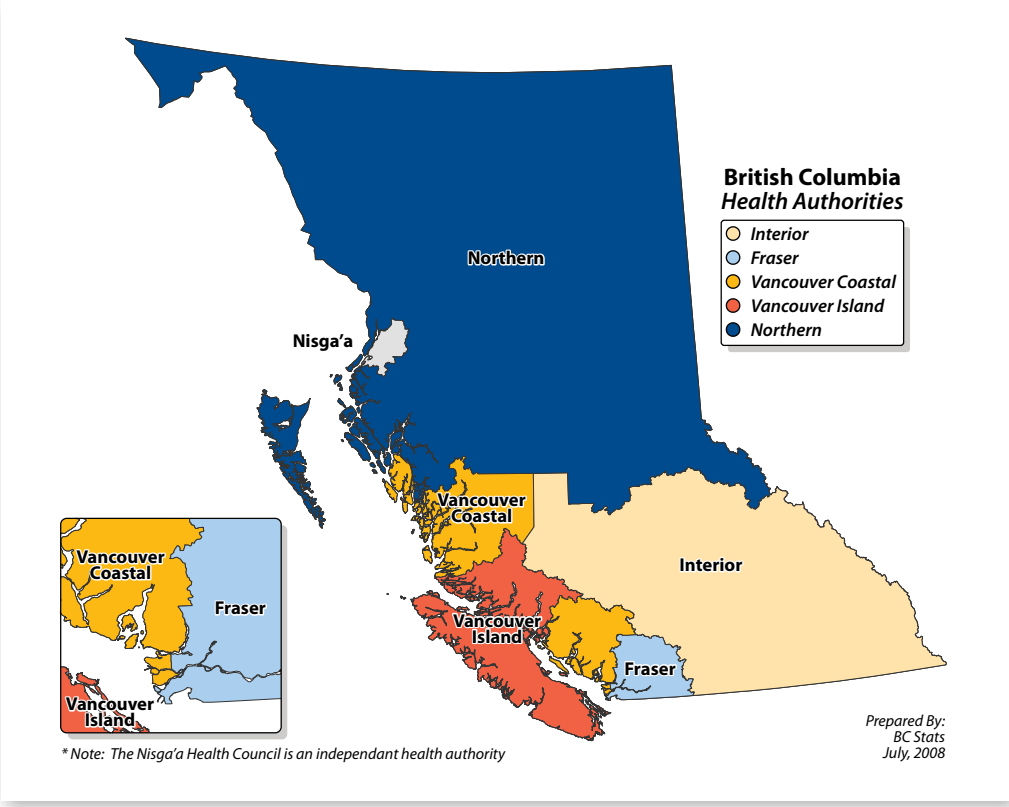
The health authorities then carefully considers those recommendations and is required to respond, to both the board and the complainant, to indicate what action(s) will be taken to address them.

2015/2016 Board Membership

> *"Thank you for getting to the truth."*
>
> **COMPLAINANT**

Board members are appointed by the Minister of Health based on their expertise and experience. Members are eligible to serve one, two or three year terms and may be reappointed to consecutive terms at the discretion of the Minister of Health. Current employees of the health authority, including board members and contractors, are not eligible to serve on the boards.

This year, we would like to acknowledge the contributions of board member Dr. John Gilbert, departing from the Fraser/Vancouver Coastal/Provincial Health Services Review Boards, and Michael Patterson, departing from the Vancouver Island Review Board.



Fraser Patient Care Quality Review Board

Hanne Madsen, chair
R. Hoops Harrison
Dr. Craig Beattie
Rita Virk
Vivienne Chin
Marion Lochhead
Peter Buxton, Q.C.

Vancouver Coastal/ Provincial Health Services Patient Care Quality Review Boards

Dr. Jack Chritchley, chair
Janis A. Volker
Dr. Stephen Tredwell
Robert D. Holmes, Q.C.
Dr. Naznin Virji-Babul

Interior Patient Care Quality Review Board

Thomas Humphries, chair
Donna Horning
Gloria Morgan
Dr. Randall Fairey
Dr. Robert Ross
Steven Puhallo
Roger Sharman

Northern Patient Care Quality Review Board

William Norton, chair
Lorna Dittmar
Elizabeth MacRitchie
Allison Read
Dr. David Bowering

Vancouver Island Patient Care Quality Review Board

Richard J. Swift, Q.C., chair
Ann Beamish
Nancy Slater
Dr. Linda J.A. Thomson
G. Henry Ellis

Statistical Overview | *Patient Care Quality Offices*

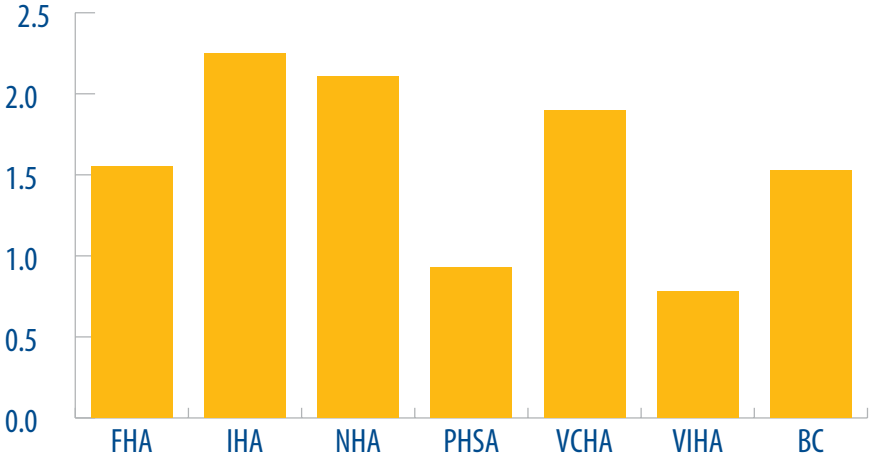
The boards collect data from the Patient Care Quality Offices regarding the number and type of complaints received by the offices in each quarter throughout the fiscal year. In 2015/16, there were 7,133 care quality complaints[1] (an increase of 26 – or less than half a per cent – from the 7,107 complaints received in 2014/15), 244 external complaints and 1,519 inquiries in British Columbia (see Appendix A for details). The table below presents the volume of care quality complaints received by each office between April 1, 2015 and March 31, 2016.

TABLE 1: *Volume of Care Quality Complaints by Health Authority and B.C.*

HEALTH AUTHORITY	Apr-June 2015	July-Sept 2015	Oct-Dec 2015	Jan-Mar 2016	Total 2015/16
Fraser Health	463	450	419	470	1802
Interior Health	285	261	268	298	1112
Northern Health	82	89	78	82	331
Provincial Health Services Authority	140	158	173	175	646
Vancouver Coastal Health	457	403	344	375	1579
Island Health	438	403	378	444	1663
BRITISH COLUMBIA	**1865**	**1764**	**1660**	**1844**	**7133**

The boards accepted 111 reviews – or approximately 1.5 per cent of the total office 7,133 care quality complaints within the same timeframe. The chart below (chart 1) shows the percentage of care quality complaints that escalated to the boards from each office over the 2015/16 period. It should be noted that this graph represents a small sample size and is subject to fluctuations year-over-year. It is not intended to be an indication of office performance.

CHART 1: *Percentage of Care Quality Complaints that became Patient Care Quality Review Board Accepted Reviews in 2015/16*



1 External complaints are defined by the ***Patient Care Quality Review Board Act*** and External Complaint Regulation, and may include complaints about services that are not funded or provided by the health authorities, or complaints that are best addressed by another entity.

Statistical Overview | *Patient Care Quality Review Boards*

In 2015/16, the boards saw an 11 per cent increase in accepted review requests – up 111 from 100 last year. This represents the most reviews accepted by the boards in a reporting year. The boards completed 97 reviews (down one from 98 last year). The table below presents an overview of the boards' volume.

In 54 of the completed reviews (56 per cent), the boards made recommendations to improve the quality of patient care and/or the quality of the complaints process itself. In 43 of the completed reviews (44 per cent), the boards did not make recommendations, having concluded that either the quality of care provided had been appropriate or that the circumstances of the complaint did not present an opportunity for care quality improvement. The boards made a total of 106 recommendations in 2015/16 – 101 to the health authorities and five to the Minister of Health.

TABLE 2: *Overview of Patient Care Quality Review Board Volume*

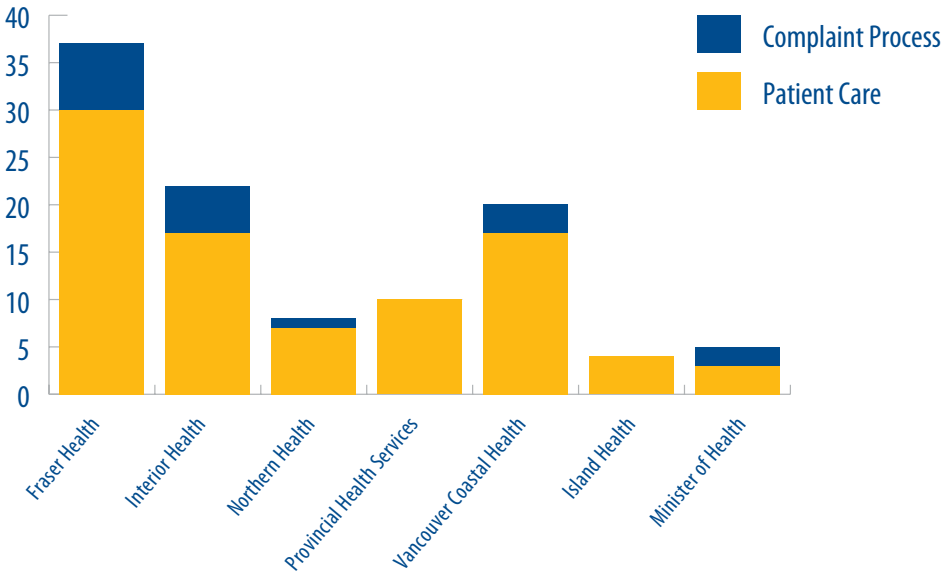
HEALTH AUTHORITY	Reviews Accepted	Reviews Completed	Cases with Recommendation(s)	Cases without Recommendation(s)
Fraser Health	28	35	18	17
Interior Health	27	20	11	9
Northern Health	7	5	4	1
Provincial Health Services Authority	6	6	4	2
Vancouver Coastal Health	30	23	14	9
Island Health	13	8	3	5
TOTAL	**111**	**97**	**54**	**43**

CHART 2: *Volume Comparison for Recommendations and Reviews*

Statistical Overview | *Patient Care Quality Review Boards*

Of the 101 total recommendations to health authorities, 85 were to improve the quality of patient care and 16 were to improve the complaints process (see chart 3 below). In 16 of the completed reviews, the boards identified opportunities for the Patient Care Quality Offices to improve the quality of their investigation or response. In the remaining 81 reviews, the boards found the offices had responded appropriately.

CHART 3: *Recommendations Concerning Complaints Process vs. Patient Care*



The boards also collect information regarding the timeliness of health authority responses to board recommendations. Under the Patient Care Quality Review Board Act, health authorities are required to respond to recommendations within 30 business days. Health authorities achieved this timeline for 40 of the 53 reviews that resulted in recommendations.

Finally, the boards track the timeliness of our own reviews. Under the legislation, the boards are expected to complete those reviews and respond within a maximum of 130 business days unless the board determines that an extension is warranted. The average time to complete a review and respond to the complainant was 157 business days. The median time was 157 days. On average, the board took eight business days to provide a response following their decision.

The chart below represents the subjects of all the complaints reviewed by the boards in 2015/16. Note that one complaint may encompass more than one care issue, so the total number of care issues will often be higher than the total number of complaints reviewed.

SECTOR	SUBJECT	#
Ambulance – non-critical care transfer	Co-ordination	4
Ambulance – Pre-hospital treatment and transport	Care	1
	Co-ordination	2
Acute care– cancer	Care	3
	Accessibility	2
	Communication	1
	Financial	1
Acute care – mental health	Attitude and Conduct	2
	Care	2
	Accommodation	1
	Co-ordination	1
	Communication	1
	Discharge arrangements	1
Acute care – other	Care	31
	Communication	9
	Attitude and conduct	4
	Co-ordination	1
	Administrative fairness	1
	Environmental	1
	Financial	1
	Safety	1
	Accessibility	1
Acute care - cardiac	Care	2
Acute care – renal	Residents' Bill of Rights	1
	Attitude and conduct	1
	Discharge arrangements	1
Administration	Communication	14
	Accessibility	2
	Co-ordination	2

SECTOR	SUBJECT	#
Administration	Challenging patient or family behaviour	1
	Lost article	2
Ambulatory care - cancer	Care	3
Ambulatory care – other	Care	6
	Discharge Arrangements	1
	Financial	1
	Communication	1
	Safety	1
Emergency	Care	10
	Accessibility	2
	Attitude and conduct	3
	Co-ordination	1
	Lost article	1
	Discharge arrangements	3
Home and community care (not including mental health)	Care	1
	Accessibility	3
	Attitude and conduct	1
	Communication	1
Mental health – community, substance use and housing	Attitude and conduct	1
	Accessibility	1
	Communication	1
Residential care	Care	9
	Administrative fairness	3
	Accessibility	1
	Financial	1
	Attitude and conduct	1
	Residents' Bill of Rights	1
	Communication	3
TOTAL		**160**

After completing a review, a board may make recommendations to the health authority and/or the Minister of Health to improve the quality of care and to improve the complaints process.

When making recommendations, the boards consider:

- The context of the complaint from both the health authority and the patient's perspective;
- The policies, procedures, guidelines, etc. that are applicable to the complaint;
- The evidence base for the recommendation;
- The potential impact of the recommendation; and
- The feasibility of implementing the recommendation.

The health authorities carefully consider recommendations and are required to respond, to both the board and the complainant, to indicate what action(s) will be taken to address them.

In 2015/16, the boards made five recommendations to the Minister of Health and 101 recommendations to the health authorities. The following presents each of the boards' recommendations that the board received a response for in this reporting period, along with some highlights of actions taken in response.

Responses received from the Minister of Health to Board Recommendations in 2015/2016

1. COMPLAINT ABOUT LACK OF CARE RECEIVED IN AN EMERGENCY DEPARTMENT FOR A NOSEBLEED.

Recommendations:

1. The board recommended that the Minister of Health review this case to determine how best to ensure effective and efficient delivery of quality patient care for low acuity problems such as the nosebleed involved here, including by:

- ***a.*** enhanced public education about when to use of the emergency department facilities and when not to;
- ***b.*** enhanced information services for the availability of physicians and clinics to deal with low acuity problems; and
- ***c.*** training programs and protocols for emergency department physicians and staff at the time of initial presentation at emergency department facilities by low acuity patients so as to encourage referrals to physician or clinic services outside of the emergency department and without taking up emergency department time and resources.

Response:

1. In response to the board's recommendation, Ministry of Health staff reviewed current information resources available to the public, established clinical practices in hospitals, and information provided by health authorities regarding the prominence of nosebleed admissions to emergency departments.

Ministry program area experts have advised that part c) of the recommendation is not consistent with established clinical practices. The potential referral of any patient must be determined by the clinical expertise and experience of emergency department staff, and it would not be appropriate for the ministry to encourage referral to other facilities. Emergency department staff assume responsibility for a patient once triage is complete, and cannot ensure a patient's safety if they advise them to seek treatment elsewhere. Conditions that present as low acuity may develop into significant concerns requiring immediate and comprehensive care that cannot be provided outside of a hospital setting.

The board expressed concern at the number of admissions to Fraser Health emergency departments for epistaxis between Nov. 1, 2013, and Oct. 31, 2014. However, admissions for epistaxis only accounted for approximately 0.4 percent of emergency department visits in Fraser Health and across BC as a whole in this time period.

Reducing unnecessary emergency department visits and improving emergency department patient flow are existing ministry priorities outlined in the 2014 document Setting Priorities for the B.C. Health System. The ministry is working with health authorities to improve management in the community care setting of patients with chronic conditions and mental health or substance use issues, in order to reduce the number of patients presenting at hospital emergency departments.

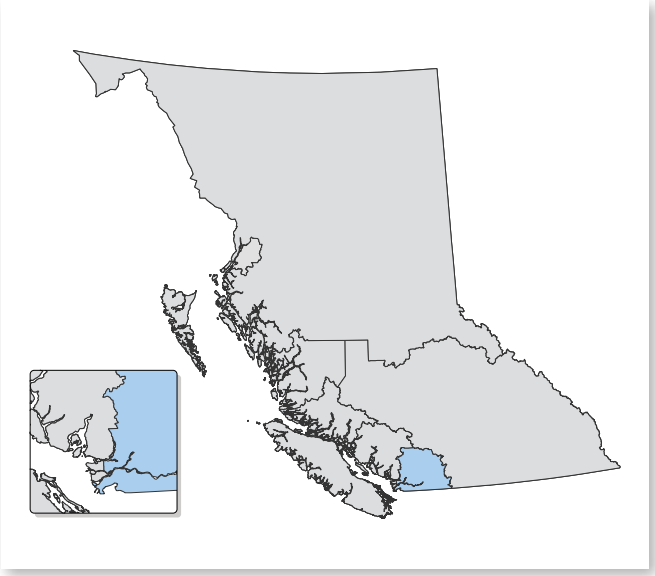
Research has indicated that public awareness campaigns regarding the use of emergency medical services have limited effect, as changes in behaviour are not generally maintained after a campaign comes to an end. However, British Columbians currently have access to a number of permanent resources that provide information and advice about where to seek an appropriate level of care.

Patients can call 8-1-1, a free provincial health information phone line service that provides patients with the ability to speak with a nurse to get advice on whether to seek care at a local emergency department. The HealthLink BC website also provides detailed information about how and where to find health services in the province. The website's "FIND Services" tool provides online mapping of urgent care and walk-in clinics, as well as navigation assistance for locating nearby health resources.

Additionally, the HealthLink BC "Smart Decisions" tool guides patients through key health-care decisions by combining medical information with their personal values.

The ministry will continue to address the concerns outlined in parts a) and b) of the board's recommendation through these existing resources and initiatives.

Recommendations and Responses | *Fraser Health*



Fraser Health is responsible for serving a densely populated and multi-culturally diverse region with more than 1.7 million British Columbians.

The boards completed their review of 35 cases from Fraser Health in 2015/16, resulting in 37 recommendations from 18 cases. Of the 37 recommendations, 30 were to improve care quality and seven were to improve the complaints process. There were no recommendations in 17 of the cases.

The board made recommendations on complaints ranging from improved communication with patients and families to improved emergency department and home and community care services. Two of the recommendations were related to the improved timeliness of responses by the Patient Care Quality Office. As a result of these recommendations, Fraser Health made a number of changes to policies and procedures within the health authority, as well as took the appropriate steps to make sure complaints addressed to the Patient Care Quality Office were responded to within the legislated time frame.

1. COMPLAINT REGARDING THE TIMELINESS OF A COMMUNITY CARE FACILITIES LICENSING INVESTIGATION FACILITATED BY THE PATIENT CARE QUALITY OFFICE.

Recommendations:

1. The board recommended that the health authority have the Patient Care Quality Office provide a timely written response to the complainant once the Community Care Facilities Licensing Office sends the completed report to them.

Response:

1. The Patient Care Quality Office committed to send the complainant a letter detailing how they may request the Community Care Facilities Licensing report through the Freedom of Information Act process.

2. COMPLAINT REGARDING AN OUT-OF-COUNTRY PATIENT'S DELAYED DISCHARGE FROM HOSPITAL BECAUSE THREE NEGATIVE MEDICAL SAMPLES WERE REQUIRED PRIOR TO DISCHARGE AND THE MEDICAL CHARGES ASSOCIATED WITH THE PATIENT'S CARE.

Recommendations:

1. The board recommended that the health authority review the charges billed to the patient in this matter, with particular attention to the days the patient was medically stable but remained in hospital for the sole purpose of providing the three negative medical samples.
2. The board recommended the health authority considers providing out-of-country patients with a daily summary of charges incurred while receiving medical services in hospital.
3. The board recommended that the physicians at the hospital involved in providing care for the out-of-country patient offer an in-service consult to inform patients who are not covered by medical insurance about the hospital's schedule of fees and any other medical costs which may be a factor while in care.

Response:

1. The health authority reviewed the care of this patient and acknowledged there were communication issues, but the overall care was deemed appropriate. With regards to having the patient provide three medical samples, the health authority stated that this was reasonable given the patient's history and presentation. The health authority was cognizant of the financial hardship for this family and for compassionate reasons, reduced the charges for medical care.
2. Each acute site has signage regarding charges for out-of-country patients. Patients are also given brochures which list the daily charges for care and caution patients that charges are not known at the time of service. Further, when admitted, patients are asked to sign a Responsibility for Payment form which lists the most common fees, a request for a $6,000 deposit, and includes a disclaimer that describes the uncertainty of final charges at that time. The Responsibility for Payment form states that physician's fees will be billed separately by the physician's office. Final bills are typically issued four to six weeks after discharge date.
3. For this patient, there were many conversations face to face and on the phone confirming the charges. In following the protocol for non-resident of Canada inpatient cases, the chart was sent to a third party reviewer for billable items and the items are coded by this company to U.S. insurance standards. This meets the Ministry of Health requirement for full cost recovery.

3. COMPLAINT REGARDING THE CARE AND CHARTING IN AN ACUTE CARE FACILITY.

Recommendations:

1. The board recommended that the health authority review the charting in this matter and determine whether further improvements can be made in instructing nursing staff, including licensed practical nurses, on the necessity of charting all significant events.

Response:

1. The health authority released an overarching Documentation Policy in 2013 that provided general guidelines on clinical documentation, applicable to all health-care professionals who document on the patient chart. In fall 2014, the policy was revised to include more information around the specific documentation requirements for several health-care professions working in the health authority. An implementation plan was developed to support educating staff on the revisions, which included completing a series of education sessions (webinars, lunch and learns, staff meetings, staff practice councils, etc.) for those particular clinical areas who requested additional support. Since January 2015, Fraser Health Professional Practice has facilitated and supported over 30 requests from managers and clinical nurse educators with targeted education in their specific clinical areas regarding the revised documentation requirements and alignment to the regulatory Standards of Practice. Based on stakeholder feedback from these sessions, a pilot was initiated in 2015 in which a representative from the College of Registered Nurses of B.C. was invited to co-present. This pilot has been successful, with an average of 40 registrants per session and positive feedback from staff with respect to content covered and the strong partnership between the college and the health authority.

Moving forward, the health authority committed to be responsive to the clinical areas requesting education on the regulatory documentation standards. Fraser Health committed to continue its partnership with the College of Registered Nurses of B.C. on co-facilitating sessions whenever possible, with a plan to extend a similar invitation to the College of Licensed Practical Nurses of British Columbia.

4. INADEQUATE CARE, DIAGNOSIS AND FOLLOW-UP OF A HEAD TRAUMA PATIENT IN AN EMERGENCY DEPARTMENT

Recommendations:

1. The board recommended that the health authority arrange for an appropriate consulting physician at [facility A] to review the [facility B] emergency department care of head trauma patients and, if appropriate, make recommendations on protocols to further improve the care of head trauma patients.

2. The board recommended that the health authority have the [facility B] emergency department develop and adopt a policy related to what reasonable steps should be taken to contact a patient who leaves the emergency department without being assessed, to ensure their well-being, and that the conclusions are documented in the nursing/physician notes that should include:

- ***a.*** reporting what was said by the nurse and patient;
- ***b.*** the time the patient was noticed to no longer be in the emergency department;
- ***c.*** whether any reason was given by the patient for the departure or whether a reason for doing so is suspected;
- ***d.*** the last known condition of the patient who left without being seen by a physician; and
- ***e.*** consideration whether or not it was planned or deemed important to telephone to check on the well-being of the patient, or to notify the emergency contact number or next of kin.

3. The board recommended that the health authority have the Patient Care Quality Office conduct a complete and thorough review of the complainant's concerns and provide a more comprehensive response to the complainant.

Response:

1. The regional medical director for trauma (and a trauma physician) at [facility A] reviewed the care provided to this patient at [facility B] with respect to processes and protocols concerning head trauma. There are no standardized processes or protocols at any of the Fraser Health emergency departments with respect to head trauma patients. Emergency physicians make use of the medical literature to guide their decisions in the acute management of head trauma.

   Most commonly, early decisions are focused on the necessity for advanced medical imaging such as computerized tomography (CT) scans and whether a patient requires urgent imaging. Decisions are guided by the history and physical exam, a standard part of any assessment. Most commonly used is the "Canadian CT Head Rule," published by Dr. I. Stiell in the Lancet in 2001. This clinical decision tool is highly sensitive in detecting brain injury requiring urgent neurosurgical intervention. Knowledge of this rule should be a part of any emergency physician's training and figures prominently in the ongoing continuing medical education that all physicians are required to take part in as maintenance of certification.

   Fraser Health reported that, based on its review of this case, urgent imaging was not indicated by the Canadian CT Head Rule and so it was appropriate to not carry out a CT scan at [facility B] during the patient's initial visits. This opinion is further supported by the CT that was performed later at [facility A], which showed no evidence of acute injury requiring neurosurgical intervention. This does not rule out concussion, which is likely what the patient suffered from. This type of injury is not evident on CT imaging. Care of concussion usually occurs in an outpatient setting and is for the most part managed by general practitioners. Referral in the community to occupational therapists sometimes occurs.

2. Documentation of patients who have left without being seen and/or assessed is part of good nursing care and will be monitored on an ongoing basis. A Pre-Code Yellow document was developed in June 2015 and implemented in all emergency departments across the health authority. This tool supports the patients who are at risk (either with medical or mental health issues) who leave before care/assessment in the emergency department has been completed or before receiving appropriate follow-up care. This is documented on the patient's chart.

3. The Patient Care Quality Office conducted another review to answer the complainant's outstanding questions.

5. COMPLAINT REGARDING OROPHARYNGEAL SUCTIONING (REMOVE SECRETIONS) IN CARE FACILITIES.

Recommendations:

1. The board recommended that Fraser Health review its policy on suctioning in care facilities if the existing policy has not been reviewed within the last two years, and that:

   a. the review determine if it is appropriate to provide oropharyngeal suctioning (remove secretions) at care facilities;

   b. the review determine if oropharyngeal suctioning is within the scope of practice for registered nurses and licenced practical nurses at care facilities;

   c. a subject matter expert, such as a respirologist, be consulted as part of the review; and,

   d. Fraser Health inform the complainant of the results of their review.

Response:

1. Fraser Health reviewed its policy on suctioning and determined that it was within the scope of practice for both registered nurses and registered practical nurses to perform oropharyngeal suctioning (remove secretions) based on a nursing diagnosis. A registered nurse/registered practical nurse can (without a doctor's order) put an instrument beyond the pharynx for the purposes of assessment, or improving or resolving a condition based on that nursing diagnosis. It is the registered nurse and registered practical nurse's responsibility to identify what they are competent at and to ask for education/support when they are not.

   It is outside the licensed practical nurse scope of practice to perform oropharyngeal suctioning. This practice is regulated by the Health Professions Act and the College of Licensed Practical Nurses – not Fraser Health. The executive medical director for Quality & Safety, a respirologist, was consulted in this review. The Patient Care Quality Office let the complainant know in writing.

6. COMPLAINT REGARDING AN INADEQUATE RESPONSE FROM THE PATIENT CARE QUALITY OFFICE.

Recommendations:

1. The board recommended that the Patient Care Quality Office provide a detailed written response to the complainant regarding the actions taken in response to the complaint with a specific focus on the training measures that were put in place, when that training occurred and how many staff members were provided training.

Response:

1. The Patient Care Quality Office updated the complainant on the specific training modules completed by care staff at the facility.

7. COMPLAINT REGARDING AN INADEQUATE RESPONSE FROM THE PATIENT CARE QUALITY OFFICE.

Recommendations:

1. The board recommended that the health authority provide the complainant with the long term care facility's response to the Fraser Health Community Care Facilities Licensing investigation, and if the health authority is unable to provide it directly, that they inform the complainant what steps are required to complete to obtain it.
2. The board recommended that the Patient Care Quality Office work with Fraser Health Community Care Facilities Licensing to develop an improved process for handling care quality complainants originating in licensed care facilities, with the aim of informing complainants of the investigation process and notifying them of the results.
3. The board recommended that the Patient Care Quality Office take steps to improve its case management process to ensure that the progress of cases is continually monitored and that complainants are kept informed of important developments, regardless of any planned or unplanned leaves of absence by patient care quality officers.

Response:

1. The Patient Care Quality Office sent the complainant a letter detailing how they may request the Community Care Facilities Licensing report, and facility response to Community Care Facilities Licensing through the established freedom of information process.
2. The Patient Care Quality Office and Community Care Facilities Licensing met to discuss the concerns, and will continue to develop a working partnership to determine which quality concerns fall under which operational area. If there are aspects of the complaint that fall under the Community Care Facilities Licensing scope of practice, the Patient Care Quality Office will work with Community Care Facilities Licensing to update the complainant on any recent developments and when the investigation is complete.
3. The Patient Care Quality Office made substantial process changes with the goal of enhancing service delivery developments. Operational changes within the department were made to increase effectiveness and efficiency, including updating the health authority's Complaints Management policy to better meet legislated targets for response times. The combined changes to the overall process of managing complaints resulted in minimizing delays in resolving care concerns and improving the patient and family experience in most cases. The health authority increased the staffing of the Patient Care Quality Office in order to better facilitate the timeliness of follow-up.

8. COMPLAINT REGARDING THE CARE AND COMMUNICATION IN A HOSPITAL BETWEEN THE EMERGENCY DEPARTMENT AND THE MENTAL HEALTH & SUBSTANCE USE PROGRAM.

Recommendations:

1. The board recommended that the health authority consider implementing a protocol to improve charting and communication between the emergency room physicians and psychiatry in situations where a patient is medically cleared by the emergency room physician, referred to psychiatry and subsequently discharged from hospital.
2. The board recommended that the health authority review this case for the purpose of ensuring that when a patient presents at the emergency room with a supporting family member, the family member's observations and concerns about the patient are carefully considered by the emergency room physician when assessing the patient and that the family member is assured their concerns have been taken seriously.

Response:

1. Fraser Health has a process that states that the emergency room physician is the most responsible physician for the patient unless the patient has been referred to and accepted by another service. In this case, the patient presented to the emergency room with a medical condition, and the most responsible physician requested a consultation from Mental Health & Substance Use program. The patient was not transferred to that program, and thus should have been discharged by the emergency room physician. The department heads for both emergency and the Mental Health & Substance Use program committed to review the most responsible physician policy to make sure that communication between both services is clear and effective.
2. The hospital department head will bring this case to the regional department of emergency medicine quality to share the lessons learned, recommendations with respect to the medical diagnosis and management of patients presenting with lactic acidosis.

9. COMPLAINT REGARDING A CHANGE IN POLICY TO AN OUTPATIENT PROGRAM WHICH REQUIRED PATIENTS TO "STEP-OUT" OF THE PROGRAM AFTER 18 MONTHS.

Recommendations:

1. The board recommended that the health authority review the step-out portion of the program and evaluate its effectiveness based on clinical evidence.
2. The board recommended that the health authority ensures that the program provide the complainant with adequate evidence based reasoning for their personal step-out from the program.
3. The board recommended that the health authority ensure that individualized care plans be developed for clients of the program that includes input from the patient, the health authority, the family physician and other health professionals involved in the patient's care.

Response:

1. Fraser Health reported that the outpatient program team carefully examines client circumstances and clinical progress when consideration is given to a step-out period in therapy. For some individuals, recovery may take years and often happens in non-linear stages. Clients are only considered for a step-out process after a significant trial of active treatment where clinical progress has reached a plateau or there has been minimal progress. Every effort is made to provide the client with appropriate resources and support during the step-out period. The step-out portion allows for the possibility of clients returning back into active treatment with the program.

   After completion of the 18 months of services, the step-out process has been shown to be very successful with specific clients on a case-by-case basis as it provides them with an opportunity to use the skills and knowledge acquired from the program in their respective community.

   The step-out process also offers the following benefits: opportunities to consolidate and work on rehabilitation and recovery plans for the clients once they have had an opportunity to learn proper coping skills, encourage clients to integrate back within their respective milieus/community in a timely manner so that they can works towards continued recovery, and allows for flow through within the program so that clients can receive timely intervention so that people are not left on the waitlist with minimal service. Reducing waitlist times and allowing individuals to access treatment quicker leads to better recovery rates.

2. The health authority has attempted to provide the complainant with reasons for their inclusion in a step-out period. The complainant was provided with the opportunity to meet with a therapist to discuss plans for their personal step out to make sure they understood the step-out policy, and to include their family doctor in this process. Every effort was made to help the complainant connect with adequate community resources to provide them with the most appropriate treatment for their complex needs. The complainant declined to meet with the therapist or a dietitian.

   The complainant was also offered an opportunity to meet with the regional program co-ordinator to discuss the rationale for the step-out process and to discuss support options. The complainant declined this opportunity. Further attempts will be made to contact the complainant to discuss treatment options (including a possible referral to an inpatient program). The complainant can also contact the regional program co-ordinator.

3. All care plans are individualized for program clients. It is a standard practice that care plans for clients are created in collaboration with the client, therapist, family physician and other health-care professionals involved in the client's care. Every effort is made to engage the client in this process, along with their community and family supports. Treatment recommendations are based on readiness and symptomatology.

10. COMPLAINT REGARDING ACCESS TO HOME SUPPORT SERVICES FOR A SPINAL CORD INJURED PATIENT.

Recommendations:

1. The board recommended that the health authority review the intake and triage process for home health services to ensure that client's receive the quality of health care they require in a timely manner by, implementing a bring forward and checklist system regarding the documentation process requirements needed for acceptance into the Home Health and/or Choice in Supports for Independent Living Programs and establishing protocols for making timely decisions about applications.
2. The board recommended that the health authority use this case as an example to implement an in-service training module to provide training and information for medical staff to recognize pertinent care quality issues regarding life threatening issues that can arise for spinal cord injured patients.
3. The board recommended that the health authority should ensure that the health authority and Home Health staff have available and are encouraged to make use of access to a consulting medical professional if they have any questions regarding spinal cord injury and the care requirements of such patients.

Response:

1. The health authority committed to conducting a review of the Home Health intake process to identify opportunities for improvement to the quality of patient care including, but not limited to: timeliness of referrals and service starts; waitlist development; documentation processes for tracking waitlists and monitoring of wait lists; and communication with clients and families about delays in service. This process will result in the development of a quality improvement plan for the Home Health Service Line, as well as recommendations to be brought forward to the Home Health clinical services network team.

   The review will include the current process for the Community Supports for Independent Living as well as the Community Living BC shared client program to identify process gaps (including the lack of a checklist and monitoring system for documents and processes related to applications) and improvement opportunities. The purpose is to make recommendations to the Home Health clinical services network team regarding the best oversight and operational structure to oversee these programs in the new structure, as well as priorities for improvement to make sure these provincially mandated programs are delivered in a patient-centred, effective way.
2. The health authority committed to conducting a review of the clinical education provided by the home health clinical resource team related to spinal cord injured patients. The review will determine what education gaps exist for both professional and nonprofessional care providers. The health authority will use this case as an example of the gaps and inconsistencies that exist in practice, and identify the elements that need to be developed and incorporated into future staff education. The review will be done using health authority experts in spinal cord injuries.
3. The Home Health regional medical director provides regular consultation to Home Health offices on issues related to clinical care. They also facilitate consultations with other specialists when needed. In the new organizational structure, the Home Health offices are aligned with acute care sites in communities, which provide them with this additional access to acute-based medical resources for specialized consultation if required.

   The director of clinical operations will work with the Home Health regional medical director to make sure there is a process in place for Home Health offices/staff to access a consulting medical professional for questions related to spinal cord injured patients. This will be developed and communicated to all Home Health managers and clinical leaders.

11. A COMPLAINT REGARDING CARE FOR A DENTAL INJURY IN AN EMERGENCY DEPARTMENT.

Recommendations:

1. The board recommended that the heath authority arrange for consultation by an expert in dental injuries, preferably a specialist in oral and maxillofacial surgery, to assess the need for possible changes in emergency department process, and to ensure timely and appropriate care for patients presenting with dental injuries.
2. The board recommended that the health authority request that the College of Dental Surgeons of B.C. provide them with a list of dentists in the catchment area of each of their hospitals who are willing to provide 24-hour emergency dental care. This will allow emergency department staff to provide information to patients who might benefit from emergency dental care.

Response:

1. The regional medical director for emergency medicine and the division head of oral and maxillofacial surgery will visit a health authority site to review the current processes. Administrative support has been approved to support this project. The health authority will request a final report and will review recommendations.
2. The regional medical director for emergency medicine has requested a list from the College of Dentistry. The executive director of the College of Dentistry is creating the list and will present that list to Fraser Health.

12. COMPLAINT REGARDING THE CARE OF A PATIENT WHO PASSED AWAY IN A HOSPITAL.

Recommendations:

1. The board recommended that the health authority instruct the regional head of medical imaging to investigate the care the patient received in preparation for, during and immediately after a computed tomography (CT) scan, with a view to determining the following:
   a. When did the patient lose consciousness, what was the significance of the patient being positioned on their back that allowed their head and neck to be hyper extended and whether or not the positioning was necessary and appropriate, and, what may have caused the hyperextension of the neck?
   b. What are the expected standards for care and monitoring of critically sick patients in preparation for, during and following their CT scan and whether in this case the staff performed those checks.
   c. Whether appropriate changes could be made to improve record keeping, charting and care in the [hospital] medical imaging department?
   d. Whether staff in the [hospital] medical imaging department have appropriate training, resources and procedures in place to identify and respond to medical emergencies experienced by patients in their care?
2. The board recommended that following the completion of their investigation, the health authority arrange a meeting with the complainant, the regional head of medical imaging and the manager of the hospital unit, to share all appropriate information.
3. The board recommended that the health authority conduct an adequate investigation into the complaint regarding an unidentified nurse and share the results of the investigation with the complainant. If the staff person described as a nurse can be identified then the complainant should be informed so that they are able to pursue their complaint with the College if they choose to do so.

Response:

1. a. The regional medical director reviewed the health record and interviewed the staff that cared for the patient. The director stated that CT scans are typically performed with the patient lying on their back, with mild variations for reasons such as patient comfort. To make a patient more comfortable during the procedure pillows are used for additional support. For this patient, the CT techs stated that "the patient was unable to lie down straight, and was propped up with sponges still leaning to the left." The director further stated that due to the patient's underlying conditions, they may have suffered an unexpected event during the CT scan, which led to loss of consciousness and hyperextension of their neck. The event may have been a stroke, heart attack or respiratory failure.

b. The degree of care and monitoring of patients undergoing a CT depends on their current condition, and is determined by the referring physician. The expectation is that if a patient requires active monitoring (e.g., pulse oximetry, blood pressure monitoring or medication infusion), the patient is accompanied by trained staff such as a registered nurse, licensed practical nurse or respiratory therapist.

The time taken to actually perform the CT scan is short – usually less than 60 seconds plus some scan preparation time. If a patient requires active monitoring, the monitors and the patient are constantly in view from the CT control area (where the CT technologists perform the scan).

CT technologists would have acted with the appropriate standard of care for their training. It is unclear precisely when there was a dramatic change in the patient's status.

c. Currently, staff record details such as contrast allergy (if appropriate), if the patient resisted the scan and complications related to the scan (e.g., contrast reaction, interstitial injection). If considered appropriate, the condition of the patient before and after the scan can be recorded using a simple numerical scale. This information entered by technologists will be reviewed, with idea of creating a standardized form for use across the region.

Medical imaging staff rely on the referring physician to ensure a patient is accompanied by appropriate staff and support persons. This can be periodically audited to make sure support and care is adequate.

d. Based on the regional medical director's review, the Medical imaging staff are trained, and have the required experience in caring for patients with a wide variety of medical conditions. All CT technologists have current Basic Life Support certification. However, imaging technologists are not expected to have medical training equivalent to registered nurses or physicians.

Resources to identify medical emergencies: Medical imaging staff have direct contact with a patient when they accompany the patient into and out of the imaging room, and while transferring the patient on and off the imaging table. The patient is constantly visible from the control room, but due to radiation exposure concerns is not directly assessed during the scan unless active monitoring is directed by the referring physician.

Resources to respond to medical emergency: A critically ill patient should be accompanied by staff from the ward, and it is expected that they would be able to identify and respond to any medical emergency. There are appropriate procedures in place to respond to an emergency, ranging from calling local staff in the department to calling a formal code blue/cardiac arrest.

4. The health authority committed to arranging a meeting with the complainant, the regional head of medical imaging and the manager of the hospital unit to share all appropriate information in regard to this case.

5. The manager of the unit contacted the complainant to determine the identity of the nurse involved. Based on the most recent description, the manager is still unable to confidently identify the nurse. The manager will bring the feedback shared in letters and phone calls to an upcoming staff meeting to emphasize the importance of demonstrating respectful and caring behavior as health-care professionals.

13. COMPLAINT REGARDING QUALITY OF HOME CARE AND ACCESS TO PALLIATIVE CARE.

Recommendations:

1. The board recommended that the health authority explain to the complainant the difference in admission requirements and care provided at a hospice residence and a residential care facility and how those might be related to the home care assessment of the patient in this case.
2. The board recommended that the health authority have the head of the Home Care Nursing program explain to the complainant:
   - *a.* what would have been the expected level of home health care and next steps for the patient when their health began to decline;
   - *b.* what care and monitoring by nursing staff and Residential Care Attendant staff is expected and what is the process of reporting and responsiveness within the system when either the family or the care provider have concerns that a higher level of treatment or diagnostic care might be required, or that the patient needs physician care; and,
   - *c.* who determines the eligibility criteria in ensuring timely access to respite care and what steps are taken from the point of decision to placement?

Response:

1. The response to the complainant included admission criteria to hospice and to residential care. The patient met the eligibility criteria for residential care and it provided the best fit for their specific care needs.
2. The response to the complainant included home care nursing protocols to monitor the client's care needs. It also included the decision-making process of planning visits to most effectively meet the needs and goals of the client and family in a complex and unpredictable situation that requires judgment to prevent a crisis in the home. The health authority has aligned its protocols with the Ministry of Health First Appropriate Bed Policy for when the client's needs increase. The respite care eligibility and access manual was also provided to the complainant.

14. COMPLAINT THAT A MISCOMMUNICATION BETWEEN HEALTH PROFESSIONALS LED TO AN UNNECESSARY SURGERY.

Recommendations:

1. The board recommended that the health authority and the local department head of surgery meet with the patient in person and explain why each surgery was necessary, how the communication arose after the second surgery, and the findings that ultimately required her to undergo three surgical excisions and to answer any further questions the patient may have.
2. The board recommended that the health authority, review with medical staff, the legislated governance under which the Patient Care Quality Office is mandated to operate, and to review with medical staff its escalation protocol and the reasons why this had to be initiated in this case.

Response:

1. The managing consultant for the Patient Care Quality Office organized a meeting with the complainant and their care providers to answer any outstanding questions they may have. This meeting was to be scheduled within two months of the health authority response.
2. The Patient Care Quality Office committed to working with the new vice-president of Medicine and the new site medical co-ordinators to inform medical staff of the process to address care quality concerns.

15. COMPLAINT REGARDING MATERNAL CARE PROVIDED BY A HOSPITAL DURING A DELIVERY.

Recommendations:

1. The board recommended that the health authority and the local head of obstetrical care at the hospital review and reassess the guidelines and protocol regarding "high-risk" pregnancies and deliveries. This review should include:

- ***a.*** The possible use of a patient safety and learning module for staff.
- ***b.*** The improvement to charting and equipment for the recognition of "high-risk" pregnancy status identification.
- ***c.*** Identification of who is the most responsible physician from pre-admission to delivery.
- ***d.*** Improvements in handover between attending obstetricians to ensure that the "high-risk" documented information alerts are communicated through all stages of labour and that continuity of care is assured.

2. The board recommended that the health authority arrange for an outside expert consultant to review the health authority's recent implementation of the Baby Pause and Skills Drill protocol and evaluate the effectiveness of the process with emphasis on fetal monitoring and offer a copy of that report to the complainant when it is available.

3. The board recommended that the health authority ensure that following the delivery of a baby who is placed in the neonatal intensive care unit or is deceased, all efforts must be made to place the family in a private room to alleviate the emotional strain on the family while continuing medical and supportive care for the mother.

Response:

1. a. The department head of obstetrical care at the hospital reviewed the file. The hospital is one of the few hospitals in the province that has the resources to provide care for both high-risk mothers and babies. The hospital is also a referral centre for hospitals in the health authority and provincewide. The perinatal team at the hospital is a 24/7, in-house team that includes obstetrics, neonatology, anesthesia, and the rapid availability of critical care, interventional radiology and full specialist support, including surgery, neurosurgery, intensive care, cardiology, infectious disease, internal medicine, renal and urology.

The hospital's Perinatal program participates in the Managing Obstetrical Risk Effectively Obstetrics program (since 2012). This national program promotes patient safety and involves all care providers, including nurses, midwives, general practitioners and obstetricians. Program topics include communication, lack of hierarchy and rehearsing emergencies. Following this case, the team participated in skills drills, with a focus on uterine rupture. During monthly morbidity and mortality rounds, identified cases are presented for discussion and recommendations to improve the patient experience. This case was reviewed at the rounds at hospital shortly after the event, and was also reviewed in a multidisciplinary patient safety review.

b. There is continuing collaboration between anesthesia and the Perinatal program to outfit an emergency cart for sudden patient emergencies. Educational rounds regarding emergency care for a sudden deterioration in maternal status, including "mock code ob" simulation drills have been conducted. In the case of sudden patient deterioration, there is immediate availability of anesthesia, the intensive care unit team and other necessary resources.

Early Recognition of the Deteriorating Obstetrical Patient Protocol was adopted by the hospital Perinatal program (including education of all nursing staff in spring 2015). To date, 90 per cent of all nursing staff have been trained. This protocol includes an obstetrical track and trigger tool that monitors vital signs and indicators for all obstetrical patients when their status moves into a high-risk category. High-risk antepartum workshops were held in January and February of 2015, with 90 registered nurses attending. Topics included assessment of high risk antepartum conditions, fetal non-stress test interpretation and documentation.

Response (continued):

The Baby Pause is a health authority project where the health-care providers discuss the fetal and maternal status in a structured format whenever a new provider comes into the patient room. The incoming nurse or midwife, general practitioner or obstetrician discuss the fetal and maternal status, review the fetal monitor strip and categorize the tracing. This review takes place in the room with the patient and family participating in the discussion, to formulate a clear plan together.

c. The Most Fully Responsible Physician is clearly identified for all patients. If there is an emergency, the in-house obstetrician on call will attend any patient immediately.

d. The handover between obstetricians is always face-to-face. There is one on-call pager for the obstetrician on-call at the hospital. The obstetrician coming off-call hands the pager to the obstetrician coming on-call and provides a detailed handover of ongoing patients. The on-call obstetrician then goes to the case room and reviews the patients with the charge nurse and nursing staff. This was discussed at a hospital Department of Obstetrics meeting in May 2015, and at the hospital Perinatal Council, making the use of Baby Pause part of the caregiver handover.

2. The executive director of the Maternal, Infant, Child & Youth program approached Perinatal Services BC to identify a clinical expert who can work with the program quality lead to support the development of an evaluation process for Baby Pause.

3. In the unfortunate circumstance when a baby is deceased, all efforts will be made to move the family to a private room. This process was approved by the [hospital] Perinatal Council – a committee of nurses, administrators, physicians, midwives, social workers and auxiliary staff. Direction has been given to all patient care co-ordinators and in-charge nurses to make the environment as comfortable as possible for the family in their difficult time.

16. COMPLAINT THAT ROUGH HANDLING OF A PATIENT IN A HOSPITAL RESULTED IN AN INJURY.

Recommendations:

1. The board recommended that the health authority have a medical professional review the patient's file and provide an explanation to the complainant of the terminology used in the radiology report of June 12, 2014 ("severe compression") and the discharge summary ("fracture") – why they differ, which is accurate and whether the complainant's description of the patient "breaking (their) back" is appropriate in light of the available evidence.

2. The board recommended that the health authority conduct a further home assessment for the patient in order to ensure that services are meeting the patient's needs.

Response:

1. The medical co-ordinator for the hospital reviewed the documents and stated that, clinically, there is no difference between the radiology report and the discharge summary. They are different ways of saying the same thing. "Compression" of a vertebra assumes a fracture. The medical co-ordinator also agreed that the interpretation by the family in saying she "broke her back" is correct.

2. An occupational therapist completed a home assessment with the patient.

17. COMPLAINT REGARDING THE CARE OF A PATIENT WHO DIED IN A HOSPITAL.

Recommendations:

1. The board recommended that the health authority ensure that when seriously ill patients require interpretation services, a qualified medical interpreter is used during critical interactions.

Response:

1. Language interpreting services at the health authority is provided by Provincial Language Services. In 2014, Provincial Language Services developed service guidelines to help all health authority employees determine when they can and should use interpreting services. Given the importance of language services in the region, Fraser Health diversity services also created the position of co-ordinator of language services in 2014. This role was designed to provide extra support and guidance to improve language services throughout the health authority in partnership with Provincial Language Services.

Fraser Health diversity services is updating its Respecting Diversity in Daily Interactions, Care Planning and System Design policy, which includes an expectation that health-care providers use effective and sensitive communication approaches, and understand when and how to effectively work with language interpreters. The health authority committed to finalizing the policy by December 2015, with full implementation expected by mid-2016.

Diversity services also identifies areas for improvement through needs assessments and feedback from staff and members of the public. They work with Provincial Language Services to develop methods to routinely evaluate the effectiveness of interpreting services and make changes as appropriate.

The health authority recognizes that effective communication between health-care providers, patients and families is a critical piece of high-quality health care. They have committed to continue to firmly advocate for the importance of using qualified medical interpreters, and are working to make this happen appropriately and consistently throughout the health authority.

18. COMPLAINT REGARDING CARE AND BILLING AT A HOSPITAL EMERGENCY DEPARTMENT

Recommendations:

1. The board recommended that the health authority review this case and initiate a protocol and in-service learning module for emergency department staff with regard to emergency department congestion issues and how to more effectively and efficiently serve the public. This would include taking into consideration the fact that low acuity problems such as the epistaxis (nosebleed) issue involved here could have been dealt with better by a referral to a physician's office or an outpatient clinic at a small fraction of the cost.

Response:

1. The Fraser Health Emergency Network, led by the regional medical director, has identified the patient experience from arrival to placement in a care space as one of its strategic priorities for the upcoming year. As part of this work, protocols to expedite the care of non-urgent patients will be produced. Identifying conditions that require an abbreviated triage or potential referral to a primary care clinic will be included. The health authority will continue to advocate with our partners in primary care to improve patient attachment and provide opportunities for minor, but urgent conditions to be treated in a non-emergency setting. Development of the protocol and site education and training will begin in September 2015 and be implemented throughout the health authority by September 2016.

"Thank you for your hard work."

COMPLAINANT

CASE STUDY | Acute Care

A patient tested positive for an influenza virus in hospital. As a result, he was started on a five day course of medication. To help prevent the spread of infection, he was placed in a private room as per the hospital's infection control policy. The patient felt that he was left in the room alone for extended periods of time with nothing to do and was not allowed magazines or newspapers to read.

After a review of the complainant's medical records, the board found that while the complainant received effective and good quality medical care, his emotional and social needs were not fully met.

Recognizing that isolation can be a very stressful experience for patients, the board recommended that the health authority consider strategies designed to better support the social needs of patients restricted to isolation rooms, including access to print and electronic information and communication technology. The board noted that most hospitals do have volunteer and pastoral care services that may be able to assist patients who need companionship.

As a result, the health authority committed to revise the clinical practice documents concerning isolation to prompt staff to consider and attend to the social needs of patients restricted to isolation rooms. In addition, the health authority committed to revise the patient education material to encourage patients in isolation to raise any concerns they may have with their care teams.

Interior Health is responsible for a broad geographic area of over 216,000 square kilometres, including both larger cities and rural communities, with a population of more than 700,000 people.

The board reviewed 20 cases from Interior Health in 2015/16, resulting in 22 recommendations in 11 of those cases – 17 for care quality improvement and five for improving the complaints process. There were no recommendations in nine of the cases.

Many of the board's recommendations to Interior Health focussed on improving home and community care services. For example, the board recommended the use of electronic monitoring of residents in dementia units be reviewed in all residential care facilities to improve resident safety. As a result, Interior Health conducted a review to ensure facilities had sufficient standardized equipment that met the needs of the different types of client groups.

1. COMPLAINT REGARDING THE QUALITY OF CARE AT A RESIDENTIAL CARE FACILITY.

Recommendations:

1. The board recommended that the health authority consider having the Patient Care Quality Office develop a methodology for the determination of when a formal closing letter should be sent to a complainant.

Response:

1. The director for the Interior Health Patient Care Quality Office discussed the board's recommendation and the factors that should be considered in a decision on how to respond to a complainant. These include:

- ***a.*** Complainant requests a written response;
- ***b.*** Complaint is of significant complexity;
- ***c.*** Complainant received a verbal response but is looking for clarification; and
- ***d.*** Health Care Protection program recommends the Patient Care Quality Office provide a written response.

These factors will be introduced into the orientation for new officers as they join the Patient Care Quality Office.

2. COMPLAINT REGARDING A PATIENT BEING NEGLECTED IN RESIDENTIAL CARE.

Recommendations:

1. The board recommended that the health authority have a home and community case manager review the resident's interRAI assessment, and if necessary complete a new assessment, to ensure that the resident receives the appropriate level of care based on their most current care needs.
2. The board recommended that the health authority ensure the residential care facility include each resident's representation agreement on file, and that all staff are trained in understanding representation agreements and how they may impact communication with family members and representatives.

Response:

1. Clients in residential care receive an interRAI assessment every three months. This assessment is conducted by a registered nurse at the facility rather than a home and community care nurse.
2. Interior Health recognizes the importance and impact of the board's recommendation and will offer resources if required to support training at the facility.

3. COMPLAINT REGARDING MISDIAGNOSIS IN AN EMERGENCY DEPARTMENT FACILITY RESULTING IN DEATH.

Recommendations:

1. The board recommended that the health authority provide in-service training for triage staff at this site on listening and giving appropriate weight to information provided by a patient's family and friends, including the asking of probing questions of the patient and family to provide the optimal diagnosis at the time, particularly when the possibility of a stroke has been raised by the family.
2. The board recommended that the health authority ensure that the BC Guideline "Stroke and Transient Ischemic Attack – Management and Prevention" is understood and implemented by triage staff.
3. The board recommended that the health authority use this case as a learning opportunity regarding when it is appropriate to transfer patients from rural facilities with limited services to larger centres, specifically when patients present with symptoms of TIA/stroke, or symptom are reported by family and friends.

Response:

1. The health authority will make sure all staff at the site knows the Canadian Triage Assessment Scoring education and understands the BC Guideline "Stroke and Transient Ischemic Attack – Management and Prevention." The local rural nurse educator will focus on reviewing the signs and symptoms of stroke, and reviewing the pre-printed orders "Stroke/TIA ED diagnostics – Rural & Remote Sites" for the health authority. This will include ensuring an adequate history is taken, including from the family or care provider accompanying the patient to the emergency department.
2. The staff will understand the BC Guideline "Stroke and Transient Ischemic Attack – Management and Prevention" as the pre-printed order is based on this guideline.
3. The health authority will produce a summary of the case, as well as the board's recommendations and the health authority's actions and follow-up. The case will be presented at various venues across the health authority.

4. COMPLAINT REGARDING NOT RECEIVING A TEMPORARY RATE REDUCTION FOR HOME AND COMMUNITY CARE SERVICES.

Recommendations:

1. The board recommended that the health authority reassess the client rate under Chapter 7 Section D of the Home and Community Care Policy Manual, taking into consideration the definition of family member when determining whether a client is eligible to apply for a temporary rate reduction.

Response:

2. The health authority will provide a response when the Ministry of Health provides direction around the alignment of the definition of "family" and "family member" in the Home and Community Care Policy Manual.

5. COMPLAINT REGARDING A PATIENT'S NEGATIVE EXPERIENCE IN A SHARED HOSPITAL ROOM.

Recommendations:

1. The board recommended that, based on best practices, the health authority develop additional direction for staff on how to manage patients who develop post-operative delirium after they have been assigned to a shared hospital room.
2. The board recommended that the Patient Care Quality Office provide a written response to the patient's complaint.

Response:

1. The health authority forwarded this recommendation to the policy steward responsible for policy "AH3000 Assignment of Hospital Rooms." The policy steward and the Professional Practice Office will assume responsibility for examining the policy and determining how best to incorporate the issue of patients who develop delirium into the policy.
2. The Patient Care Quality Office will write to the complainant in response to the complaint, sharing the additional information and the follow-up to the first recommendation.

6. COMPLAINT REGARDING PALLIATIVE AND PAIN MANAGEMENT CARE.

Recommendations:

1. . The board recommended that the health authority implement a 24/7 pain management service at the hospital to provide expert consultation, advice and support in pain management to staff which could include:
   - ***a.*** an in-service training module for staff to understand and utilize this new service,
   - ***b.*** an anesthetist interested in pain management ,
   - ***c.*** a consistent care plan be put into place for each patient requiring severe pain management in hospital,
   - ***d.*** communication with patient and family regarding pain management support,
   - ***e.*** facilitation of patient transitions to community hospice services by increasing collaboration with the Palliative Care Coordinator
2. The board recommended that the Patient Care Quality Office follow up with the complainant regarding the changes to palliative care and pain management, and indicate when these changes will be implemented.

Response:

1. The health authority recognizes the importance of specialized services, such as a pain management and has been engaged in the development of a chronic pain strategy since 2012. Key elements include: improving access to enhanced existing resources; establishing new services to create a comprehensive, co-ordinated and multidisciplinary network of pain services; and education strategies for patients, families and the multidisciplinary team on the nature, treatment and management of chronic pain.

   Currently, chronic pain care is provided in a wide variety of organizations including family practitioners in their office environments; specialist physicians (anaesthesiologist, radiologist, physiatrist) in hospitals and specialty clinics; and by other private practice health professionals including physiotherapists, massage therapists and complementary alternative medicine providers and others. Physicians in the health authority (including anaesthetists, radiologists, and family practitioners) are providing interventional pain management services.

   Chronic pain services are provided at [the facility], supported by an outpatient chronic pain team that serves the entire region. Given the need and significant financial investment of chronic pain service, Interior Health has placed the chronic pain strategy into the process for consideration of additional funding when it becomes available. Additionally, the health authority is developing a plan to provide education for pain and symptom management as part of the strategic planning for palliative and end-of-life care. Care planning for pain management – in collaboration with the patient and family – is now part of a strategy, which has been put in place at all acute care sites. This strategy focusses on six basic functional care areas known to be barriers to discharge, regardless of primary diagnosis. Pain management is one of them. This strategy applies to all admitted inpatients (except obstetrics and newborns).

   The manager for community integrated health services with responsibility for the [program] attends daily access and flow rounds with the acute care team. Patients are identified who might be eligible for a hospice bed at this meeting and occupancy and wait times discussed. With the Ministry of Health mandating that health authorities double the number of hospice spaces available, [city] will designate beds in the new tower as hospice beds and those patients will be co-located to facilitate the introduction of a palliative care program.
2. The Patient Care Quality Office committed to following up with the patient as recommended.

7. COMPLAINT REGARDING THE NUMBER OF HOME CARE HOURS BEING RECEIVED.

Recommendations:

1. The board recommended that the health authority ensures that the contracted home care services program provides the allotted 152 hours of single person care, or 104 hours of two person care to the client as allocated under this client's 2015 Community Care Service Agreement.
2. The board recommended that the health authority conduct a comprehensive re-assessment of the client's care needs, in addition to the 2015 Community Care Service Agreement, including a neuropsychological re-assessment by an appropriate registered health professional to be compared to the neuropsychological assessment done at the [facility] at the time of the patient's original accident. Specifically, whether there have been changes in the client's capacity, abilities and behaviours.
3. The board recommended that the health authority work with the complainant to find a mutually agreeable arrangement to ensure the complainant's health and safety needs are also met in their role as caregiver to the client. This should include:
   a. A financial re-assessment to ascertain the care and services, including respite care, caregiver respite and any other health authority subsidized programs, for which the client and complainant are eligible.
   b. A social work assessment to ascertain the programs that are available to the complainant, including a fulsome discussion and description of respite care and assisted living services.
   c. A caregiver re-assessment, including a stress assessment and an assessment of the complainant's home environment to ascertain what they require in order to maintain the caregiver role.

Response:

1. As of [date] the contracted provider of home care services is providing care from 0900 to 1500 hours on Monday, Tuesday, Wednesday, Thursday and Friday or five days a week for six hours a day. Home care services are also providing care on Saturday and Sunday with the possibility of increasing care on Saturday if the opportunity arises. The complainant is satisfied with this schedule. The occupational therapist and a staff member from the contracted provider are visiting the client's home with the new worker to make sure she has training/direction to help her respond appropriately to the client and manage behaviours. The training uses a technique that allows one worker to provide care at a time. Workers are consistent with the current schedule.
2. It is important to recognize the challenges faced in rural areas to recruit and maintain appropriate staff to deliver care. As well, Interior Health cannot insist that the contracted provider send staff into a home where they may feel bullied or harassed. It is reported that the client commented that their experience was very positive. They were very appreciative of the care provided in the residential setting, and it is further reported that their attitude has changed since this admission to care.
3. A referral will be forwarded to the local geriatric assessment team. This team includes the expertise of a geriatric psychiatrist. Neuropsychology services are not available in this area. The RAI assessment was completed for this client on [date] and a financial assessment was completed on [date]. These assessments are conducted annually or whenever there is a change in status of the client.

   As noted above, the client and family caregiver underwent a RAI assessment. The community care case manager recently spoke with the complainant about a temporary rate reduction in order to assist with the expense of respite. The case manager will review this process with the client again as the complainant would like her husband to receive respite care two days/month in a short stay residential setting. The community care case manager is responsible for the actions outlined in bullet (b) and (c), and these discussions and assessments have occurred on a regular basis. The stress this caregiver was under was already apparent and responded to, given the resources available in this area and the high needs of this client.

8. COMPLAINT REGARDING A PATIENT SUFFERING A FALL IN A RESIDENTIAL CARE FACILITY RESULTING IN DEATH.

Recommendations:

1. The board recommended that the health authority conduct a review of all residential care facilities regarding the use of electronic monitoring (e.g. fall mats, bed monitors) of residents in dementia units to ensure resident safety.
2. The board recommended that the health authority conduct a review of the charting method and documentation used in the facility to ensure sufficient information and details are included in the patient chart.
3. The board recommended that the health authority encourage the use of Patient Safety and Learning System to promote learning and improve patient care in dementia units.

Response:

1. An audit has been conducted of the use of electronic monitoring equipment in the facilities where this event took place. The audit focused on ensuring that facilities had sufficient standardized equipment and met the needs of the different types of client groups cared for in residential care. The inventory of electronic monitoring is assessed quarterly by rehabilitation staff and residential managers. The inventory is increased as required based on patient population needs and equipment wear and tear.

   The use of monitoring equipment by individual clients is determined by assessment on admission to the facility, any time the status of the resident changes, and at minimum annually. The health authority has a variety of equipment available depending on the assessment. The results of the assessment are documented in the care plan so that all care staff are aware of the patient's needs and plan to address those needs. An assessment of the function of the electronic monitoring equipment is completed by rehabilitation staff every three-to-six months, depending on the type of equipment.
2. Regular reviews and quarterly audits of health records of residents are conducted to improve the results of the audits. The charting in this instance will be reviewed with a licensed practical nurse, and feedback will be provided in detail and specificity.
3. The residential programs across the health authority use the Patient Safety and Learning System to report and learn from events. The events of the morning were reported in the Patient Safety and Learning System, as well as licensing, then followed up by the manager.

9. COMPLAINT REGARDING A PATIENT BEING ALLEGEDLY SEXUALLY ASSAULTED IN A RESIDENTIAL CARE FACILITY.

Recommendations:

1. The board recommended that the health authority review this case, making sure all staff are able to identify an adverse incident, and are trained in reporting in accordance with the policy and guidelines as outlined in the health authority's Administrative Policy Manual, the Abuse Free Environment protocols and the Community Care Licensing Act.
2. The board recommended that the Patient Care Quality Office provide a full summary to the family (including a complete breakdown of the incidents), provide a report on any follow-up that took place, and provide the decision review team meeting results.

Response:

1. In response to these events, the manager of the facility met with all staff and reviewed the health authority's policy "AH0100 Abuse Free Environment for Clients" to make sure they understood the policy. The staff at the facility have been working on the completion of the health authority iLearn violence prevention modules as part of the WorkSafe BC violence prevention strategy. Residential services leadership invited the Interior Health knowledge facilitator for vulnerable and incapable adults to a health authority residential services manager meeting to speak on the topic of sexual health in residential care. On [date], management changed the staffing model to include registered nurses on day shift seven days per week and a full-time assistant manager, which has improved site communication and facilitated escalation of events to more senior management. Steps taken have seen a positive increase in reporting issues earlier, even prior to admissions. The manager and residential quality review co-ordinator for the geographical area have identified one long-term strategy and six short-term strategies to achieve improvements at the site. Residential services leadership has committed to drafting a de-identified Patient Safety and Learning Summary, which will include all of the immediate actions that occurred following the event – including the strategies flowing from the quality review.
2. The director for the Patient Care Quality Office has taken responsibility for providing a response to the concerns raised by the family, including the follow-up completed at the site and by residential services leadership. The board will be copied on the response to the complainant.

10. COMPLAINT REGARDING THE CARE A PATIENT RECEIVED AT A RESIDENTIAL CARE FACILITY.

Recommendations:

1. The board recommended that the health authority conduct a further review of this complaint, and provide the complainant with a progress report clearly explaining what changes have been made at the facility to address the unresolved issues of this complaint.

Response:

1. The Interior Health residential services team met and took actions to improve allergy recognition, food menu choices, staffing levels and other improvements to make sure residents receive their bath according to their individualized care plan. The health authority noted that a review was not necessary, but provided clarification to the complainant, the minister, and the board about the improvements being made. Since then, the complainant is satisfied that care and staffing levels have improved at the facility. The residential services team will monitor these issues through regular quality reviews and licensing inspections.

   Interior Health changed red trays to red tray tags in response to the complaint and the fact that rice had been served to the complainant's mother who was allergic to rice. The health authority apologized to both the board and the complainant that this was not entirely clear.

   In response to the complainant's bathing concerns, more staff have been trained in the bathing process, and a process has been put in place to extend shifts or add staff the next day to ensure missed baths are rescheduled as quickly as possible. As well, the residential care co-ordinator can approve overtime without management authorization to allow baths to occur as scheduled.

Response (continued):

In response to the food menu choices, the health authority implemented the "Aladdin System" for hot holding of food for tray service (an insulated food server that uses thermal column technology to keep hot foods hot and cold foods cold). In addition, seven fruit and vegetable items are always available on the menu daily. However, in order to provide variety within the texture restrictions in place for many residents, canned fruits and vegetables rather than fresh may be served. Short stay clients, including the complainant's mother, are often able to manage more challenging textures. As a result of the complaint, food services has posted a sign in the dining area indicating that fresh produce is available upon request. Residential services will also be adding this information into the handbook provided to residents on admission.

The Patient Care Quality Office director committed to write to the complainant and clarify that the changes made were a direct result of the concerns raised by the complainant.

11. COMPLAINT ABOUT A PATIENT NOT RECEIVING APPROPRIATE PHYSIOTHERAPY SERVICES.

Recommendations:

1. The board recommended that the health authority conduct a review of the operations of outpatient rehabilitation departments, and that the review:

- ***a.*** include, at a minimum, outpatient rehabilitation departments at [facility], [facility], [facility], as well as any other departments in the [region] or in Interior Health that the health authority determines would benefit from review;
- ***b.*** be conducted by an expert in outpatient rehabilitation operations from outside of the [region];
- ***c.*** evaluate the effectiveness of the departments' case management systems and practices, including:
  - ***i.*** How referrals are received, documented, approved/not approved and followed up on;
  - ***ii.*** How communications with patients and referrers are documented and followed up on;
- ***d.*** evaluate whether existing levels of administrative support are appropriate.

2. The board recommended that the health authority have the [facility] review the decision to not provide the patient with additional physiotherapy as requested by their family physician on [date].

Response:

1. The administrator for allied health and director of allied health Interior Health East committed to delivering a review of the rehabilitation services at the hospital facilities. The review will be conducted by a professional practice leader for physiotherapy services. The review will include:

- ***a.*** A review of the board analysis and recommendations.
- ***b.*** A review for each of communities and specific to hip and knee arthroplasty post-operative rehabilitation, to determine:
  - ***i.*** The tracking process and documentation of new referrals.
  - ***ii.*** The prioritization and triage process and subsequent communication to patient and physician.
  - ***iii.*** The process for developing patient centred treatment goals and reviewing service expectations in conjunction with the patient.
- ***c.*** A review of the role and capacity of administrative support for these departments.

2. The health authority committed to review the decision that the complainant was not eligible for service as described in the board report, and provide recommendations regarding process and criteria by which this decision was made.

CASE STUDY | Residential Care

A resident of a residential care facility fell and injured her knee. Staff noted some blisters forming around the site of the injury and continued to monitor the injury. Several days later, the resident's adult children visited and were alarmed by the condition of the injury. As a result, they took the resident to a hospital emergency department. At the hospital, the resident was diagnosed with a potentially serious bacterial infection and was admitted as an outpatient for antibiotic therapy. Treatment of the infection involved daily visits to the hospital for intravenous antibiotics, numerous medical appointments, and surgery to graft skin onto the wound.

The resident's family filed a complaint with the health authority, which referred the complaint to their Licensing Department. Licencing completed an investigation and concluded that staff at the facility had failed to perform a comprehensive assessment after the fall occurred, had not performed an adequate follow-up assessment and had not completed proper documentation. However, the health authority did not notify the resident's family of the results of the investigation. When the resident's family inquired as to the status of the investigation, they were told that it had been completed, and if they wished to see the results, they would need to file a freedom of information request.

The board recommended that the health authority provide the resident's family with a copy of the residential care facility's response to the Licensing investigation, work to improve the health authority's process for handling care quality complaints originating in licenced care facilities, and take steps to make sure that complainants are kept informed of important developments. The health authority subsequently committed to implementing the recommendations of the board.

Northern Health is responsible for serving over two-thirds of B.C.'s landscape, with nearly 300,000 people spread over a broad geographical area.

The board reviewed five cases from Northern Health in 2015/16, resulting in seven recommendations for care quality improvements and one recommendation for improving the complaints process in four of those cases. There were no recommendations in one case.

Recommendations by the board this year included education for care staff related to a specific disease, communication around wait times, communication around medication, transferring of patients and record keeping. The health authority was receptive to the recommendations and has been working to implement them in the region.

1. COMPLAINT REGARDING A PATIENT DIAGNOSED WITH AMYOTROPHIC LATERAL SCLEROSIS (ALS) BEING DENIED CARE.

Recommendations:

1. The board recommended that the health authority initiate an in-service education program for all staff, including care aides, that is designed to improve their understanding of the disease and the care needs of a patient diagnosed with ALS and that new staff coming into the facility are made aware of the comfort care and needs of a person diagnosed with this affliction. The Northern Health initiate an in-service education program for all staff that is designed for improving the understanding of the disease and care of patients diagnosed with ALS.

Response:

1. Northern Health will develop an in-service training program, which will be provided to all care staff at facilities that have an ALS resident.

2. COMPLAINT REGARDING A PATIENT'S WAIT TIME FOR EYE SURGERY.

Recommendations:

1. The board recommended that the health authority initiate a written follow-up process in the surgical booking office which will include confirmation of the patient's scheduled surgical procedure in writing by way of letter or email offered to the patient at the time of booking.

Response:

1. Northern Health advised that they were currently in the first phase of implementing the Cerner Surginet Information System, which includes a booking module, across all Northern Health facilities that provide surgery. The Surginet booking module has the capacity to generate a booking confirmation letter that could be sent by mail or by email. Once the system has been fully implemented, Northern Health will be able and willing to initiate the written confirmation.

3. COMPLAINT REGARDING THE TRANSFER OF A PATIENT WITH A LIFT.

Recommendations:

1. The board recommended that the health authority review the policy and procedures on the use of lifts and transferring of patients with the staff members identified to ensure that their training and competencies are current.
2. The board recommended that the health authority provide empathy training to the nurse identified in the complaint about her behaviour and attitude.
3. The board recommended that the health authority review the investigation and response by the manager of diagnostics and that the health authority ensure that all incidents regardless of where they occur in the hospital be recorded in the Patient Safety and Learning System as well as the medical chart.

Response:

1. The clinical nursing educator on the internal medicine unit (IMU) of the [facility] will review the safe patient transfer policies with all nurses to make sure their training and competencies are current.
2. The manager of the IMU at [facility] will make sure all unit nurses have completed "Person and Family Centred Care" training, which includes education on an empathetic approach to patient and family conversations.
3. The manager of diagnostics will review this complaint, and risk management will provide incident investigation training for all [facility] managers over the next six months. Northern Health currently has a policy in place requiring that all patient safety events are documented in the patient record, and that safety concerns and recommendations for quality improvements are reported in the Patient Safety and Learning System. All [facility] education will undertake refresher education on the Patient Safety and Learning System over the next year.

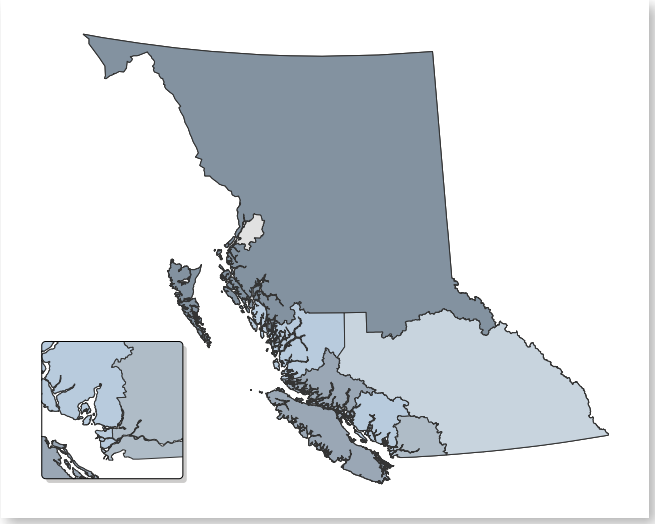
4. COMPLAINT REGARDING MISCOMMUNICATION ABOUT A PATIENT'S MEDICATION.

Recommendations:

1. The board recommended that the health authority ensure that a comprehensive orientation is provided to new and contracted staff prior to that staff member commencing work on a ward and that it direct all new and contracted staff that if they are unsure of a policy or procedure that they check with the nurse leader on the ward for clarification and direction.
2. The board recommended that in order to maintain a positive healing environment the health authority provide nursing staff at [facility] with communication training, with particular emphasis on de-escalation techniques where conflict arises when caring for patients.
3. The board recommended that the health authority ensure that the hospital understands that it is responsible for the administration of all the patient's medications while that patient is in its care to prevent a medication error.
    - ***a.*** If for any reason the patient is permitted to take their own medications, then they must be reconciled with the physician's orders and the pharmacy before the patient's medications are returned to them;
    - ***b.*** That this policy be clearly communicated to patients who request to take their own medications; and
    - ***c.*** In the event of a potential medication interaction, that an explanation is provided to the patient for the reason why there might be a change in the type of drug provided, dose or time of administration.

Response:

1. A new role in the health authority was created. The regional director of HR planning & design and education is a new position that will focus on all aspects of education and training. Work will be started on determining the health authority's education needs, including ensuring a comprehensive orientation program is available to all new and contracted staff.
2. The [region] administrator is working to improve the clinical communication between practitioners by using the SBAR (situation, background, assessment, recommendation) tool. The facility is committing to provide SBAR education twice yearly so that new staff members are aware of how to effectively communication with physicians. Also, staff that have yet to complete the Northern Health Conflict Resolution training will be identified and encouraged to complete the training. This training will help staff form a foundation for de-escalating conflicts that arise with patients, physicians and other staff.
3. Changes have been made to the Patient's Own Medication Policy that will improve clarity for both nursing staff and patients. The policy makes reference to patient's own medications being reconciled by the pharmacy. The policy also makes provisions for facilities that do not have a pharmacist on site, providing more clarity for the nursing staff in those facilities. The policy is in the final draft stage and will be made available to all staff members once it is approved, who can then make it known to patients. Northern Health agreed that it is very important for patients to be aware of the policy and the medications that are being administered. Northern Health aims to keep patients informed about all aspects of their care.



Instead of a geographic region, the Provincial Health Services Authority (PHSA) is responsible for specific provincial agencies and services. There are numerous agencies and programs that fall under the purview of the PHSA. These include: BC Cancer Agency, BC Centre for Disease Control, BC Children's Hospital and Sunny Hill Health Centre for Children, BC Mental Health and Addiction Services, BC Provincial Renal Agency, BC Transplant, BC Women's Hospital and Health Centre, Cardiac Services BC, Perinatal Services BC, BC Emergency Health Services, BC Autism Assessment Network, Health Shared Services BC, PHSA Aboriginal Health program, Provincial Blood Coordinating Office, Provincial Infection Control Network of BC, Provincial Surgical Services program, Provincial Emergency Services project, trauma, specialized diagnostics, specialized cancer surgery and telehealth.

The board reviewed six cases from PHSA this period, resulting in ten recommendations for care quality improvement in four of those cases. There were no recommendations in two of the cases.

Two of the board's recommendations were related to the BC Ambulance Service – one regarding the care provided by paramedics to a patient following a fall, and the other related to delayed ambulance service.

1. COMPLAINT REGARDING THE LACK OF AN OPERATING ROOM FOR THE TREATMENT OF A RARE FORM OF CANCER.

Recommendations:

1. The board recommended that the health authority have the head of surgical oncology review this complaint, the physician's letter to the complainant and the complainant's chart (to the extent appropriate) and set out for the complainant an explanation in plain language of the following:

- ***a.*** The process of review of patients such as the complainant where different surgical procedures are potentially available treatments, and how the protocol used in this matter affects the recommendations made by the BC Cancer Agency;
- ***b.*** Whether the protocol is applied rigidly or whether "unique circumstances" of a patient are considered to make exceptions to the protocol; and,
- ***c.*** Whether performing the required type of surgery in a hospital operating room setting in BC was available as a possibility, if it was deemed medically appropriate and recommended.

Response:

1. The vice-president of radiation and surgical oncology, in conjunction with a BC Cancer Agency surgical oncologist, committed to conduct a review of the case and provide a letter back to the patient with the findings, including the points noted within the board's recommendation.

2. COMPLAINT REGARDING THE CARE PROVIDED TO AN INFANT IN A NEONATAL INTENSIVE CARE UNIT.

Recommendations:

1. The board recommended that the health authority have the hospital (a) reinforce with nursing staff the importance of relaying information, especially concerns raised by the mother to the physician responsible for the infant's care, (b) ensuring that the patient's family are always able to identify which physician is in charge and are informed when care decisions are made.
2. The board recommended that the health authority have the Patient Care Quality Office provide the complainant with a list of the physicians and their specialties that were involved in the infant's care.

Response:

1. The neonatal program implemented an early warning sign/parent concern escalation protocol, NEWS (neonatal early warning signs). The NEWS system contains an algorithm about when to call, to whom, and what the expected timelines are to the response. The NEWS protocol was finalized in July 2014. Education on the protocol occurred between July-November 2014. The NEWS Simplified was placed at every bedside in the neonatal intensive care unit by September 2014. There is ongoing education on the protocol in the neonatal intensive care unit for staff and new hires to the unit.

   Every morning, the unit designates the name of the physician responsible for each patient on the status board in the hallway. In order to further clarify for each family which physician is in charge, every patient in the neonatal intensive care unit has a status board at their bedside. The unit committed to institute a practice where the physician name that is on service during the day is written on the board along with all of the other members of the care team. The unit invites all parents to attend daily interdisciplinary rounds where the care of their child is discussed. The care team will identify the most appropriate person to contact the family when major care decisions are made if parents are not present. The neonatal program is committed to a more integrated model of care where parents are identified as key members of their infant's core care team. Within this model of care, parents participate as much as possible and provide as much of the hands on care as possible.
2. The health authority provided the complainant with lists of the on-call schedules for the neonatal intensive care unit at the time of their infant's care, as well as the names of the physicians who were documented as caring for the infant in the medical record.

3. COMPLAINT REGARDING THE CARE RECEIVED FROM BC AMBULANCE SERVICE FOLLOWING A FALL.

Recommendations:

1. The board recommended that the health authority work with the paramedic training programs to review the curriculum specifically around identification and application of appropriate care protocols for traumatic head and C-spine injury cases.
2. The board recommended that the health authority have BC Ambulance Service management take steps to improve on oversight of and communications with paramedics and ensure appropriate action and follow through with remedial training when events indicate that there are significant failures in the application of a paramedic's knowledge base.

Recommendations (continued):

3. The board recommended that the health authority have a senior or retired paramedicor physician with expertise in the application of treatment based protocols for traumatic head and C-spinal injuries – review this case and make recommendations to BC Ambulance Service on how to improve management oversight and training of paramedics so as to ensure application of such protocols in practice.

Response:

1. BC Emergency Health Services committed to engage with the Justice Institute of BC as the primary provider of (non-BC Emergency Health Services employment related) paramedic training to review educational alignment with current Traumatic Brain Injury and C-spine Treatment Guidelines.
2. BC Emergency Health Services implemented an improved process for documenting and monitoring formal learning plans as part of an overall strategy to maintain competency.
3. BC Emergency Health Services undertook a review process that considered foundational pillars for paramedic practice, including International Trauma Life Support. The course content and its relationship to BC Ambulance Service Treatment Guidelines has been reviewed by a group of senior physicians with the appropriate expertise. BC Emergency Health Services committed to also start a systematic review of clinical audit processes.

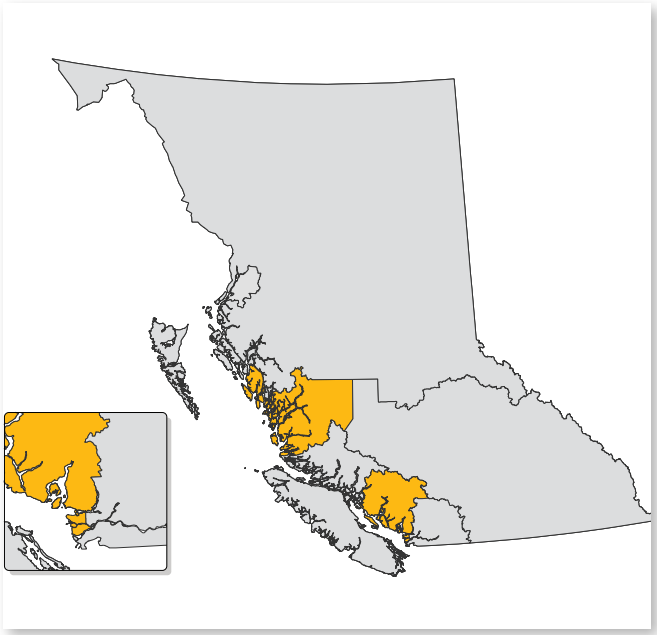
4. COMPLAINT REGARDING A DELAYED AMBULANCE TRANSFER.

Recommendations:

1. The board recommended that the health authority liaise with the BC Cancer Agency and Island Health to determine whether there is an alternative way of providing transportation services between facilities (such as private providers of non- emergency patient transport, or increasing the number of ambulances dedicated to patient transfers) so that transfers are completed in a timely manner.
2. The board recommended that the health authority:
    a. Conduct a review of the demand for triage level "green" patient transfers;
    b. Include how often since the November 2014 service amendment that patient transports were late or unavailable; and
    c. Assess if the service amendment has improved patient care and/or if further improvements or alternative service delivery options are required.
3. The board recommended that the health authority ensures the Patient Transport Coordination Centre is notified when transfers are delayed and that the centre has options available, such as obtaining private transportation or liaising with the hospital to coordinate overnight stays, to ensure that delayed transfers do not result in unreasonable delays, rescheduled appointments and poor care.
4. The board recommended that the health authority conduct a review of communications between the BC Ambulance Service Victoria Dispatch Centre, the Patient Transport Coordination Centre, and health care facilities, to ensure that measures are in place to inform health-care facilities in a timely manner if a patient transfer is delayed.

Response:

1. Responsibility and funding for non-emergency patient transfers that do not require patient monitoring has been the responsibility of the regional health authorities for several years. BC Emergency Health Services continues to work with regional health authorities and Ministry of Health executive to establish policies clarifying responsibilities for releasing ambulances promptly from emergency departments and for non-emergency transfers. This will help ensure ambulances are available to respond when paramedic services and urgent transport is required. BC Emergency Health Services is currently unable to increase the number of ambulances dedicated to patient transfers because doing so would remove them from the resources available for 911 responses.
2. As part of the referenced deployment study, information regarding ground transfers in the Lower Mainland and air transfers provincially was included in the modelling. Demand for low acuity transfers is variable, and is dependent on regional health authority service provision and their use of alternative service providers. BC Emergency health Services has completed significant work to review and improve response times for its high acuity patients (red and yellow transfers), and is planning to undertake a similar review and improvement process with regards to its low acuity patient transfers (green and blue transfers). There is a subset of these calls that require paramedic support, and these will be analyzed to establish the criteria needed in the new transfer policy referenced above. The policy will outline the responsibilities for inter-facility transfers between regional health authorities and BC Emergency Health Services.
3. Regional Dispatch Operations Centres notify the Patient Transport Coordination Centre when transfers are delayed. For those patients who do not require clinical monitoring, regional health authorities are expected to use an alternate service provider. BC Emergency Health Services committed to developing criteria for green and blue transfers. These criteria will help clarify when it is appropriate for BC Emergency Health Services to handle the transfer and when regional health authorities should be making alternative arrangements for transport.
4. BC Emergency Health Services committed to review communication protocols between the Victoria Dispatch Operations Centre, the Patient Transport Coordination Centre and the sending/receiving health-care facilities.



Vancouver Coastal Health is responsible for serving two regions with more than one million people.

The board reviewed 23 cases from Vancouver Coastal Health in 2015/16, resulting in 20 recommendations in 13 of those cases – 17 recommendations were for care quality improvement, while three were to improve the complaints process. The board made no recommendations in ten cases.

The recommendations to Vancouver Coastal Health covered a broad range of issues, including: communication related to end-of-life care and a do not resuscitate code status, assisted living services, accuracy of hospital medical records and discharge summaries, loss of belongings and an isolation protocol. In response, the health authority reviewed specific instances of care, has had staff members meet with patients and their families, and has reviewed and improved health authority documentation.

1. COMPLAINT REGARDING QUALITY AND LEVEL OF CARE IN AN ASSISTED LIVING FACILITY.

Recommendations:

1. The board recommended that the health authority undertake a full InterRAI MDS (minimum data set) assessment to determine the patient's needs for service and in what manner and what facility those may most appropriately be provided.

The board recommended that the patient be advised that they may have their family physician or any other health-care professional they designate provide information or their assessment to the case manager assigned to perform the InterRAI MDS assessment to supplement the assessment that the case manager directs.

The board recommended that if the assessment and consultation has been done, the home and community care case manager meet with the patient, as well as any representatives or advocates the patient may choose, to review and discuss the report and recommendations.

The board recommended that if the parties cannot agree, then the health authority considers arranging for a mediator to meet with the parties to see if a mutually agreeable resolution can be reached.

Response:

1. Vancouver Coastal Health committed to contacting the client to schedule the assessment.

Vancouver Coastal Health committed to reminding the client that they may have their family physician or any other health-care professional they designate provide information or their assessment to the case manager assigned to perform the InterRAI MDS assessment.

Vancouver Coastal Health committed to meeting with the client and any representatives or advocates they chose once the assessment and consultation has been done, to review and discuss the report and recommendations.

The health authority will continue to pursue a mutually satisfactory resolution that addresses the client's needs, and is in compliance with the commitment and regulatory obligation of Vancouver Coastal Health – and its contracted service provider partners – to a safe working environment for staff.

2. COMPLAINT REGARDING THE RESPONSE FROM THE PATIENT CARE QUALITY OFFICE.

Recommendations:

1. The board recommended that the Patient Care Quality Office provide a formal written response to the complainant, including in it, their regret at the length of time it took to formally respond.

Response:

1. The Patient Care Quality Office provided a formal written response to the complaint that included a sincere apology for the length of time taken to formally respond, and a detailed explanation of each complaint element and actions taken.

3. COMPLAINT REGARDING COMMUNICATION AND THE DEATH OF A PATIENT IN AN ACUTE CARE FACILITY.

Recommendations:

1. The board recommended that the health authority use this case as a teaching/learning module for medical staff with the goal to emphasize improving communications between medical staff, and between medical staff and patient/patient families both while a patient is in care and after death.

Response:

1. A consultation with the medical departments and divisions across Vancouver Coastal Health was initiated to reinforce the importance of communication with families, and to seek input on strategies for improvement in communication within the health-care team.

4. COMPLAINT REGARDING THE DENIAL OF ASSISTED LIVING SERVICES.

Recommendations:

1. The board recommended that the health authority have the complainant's case manager ensure that:

- ***a.*** All available living arrangements and options for alternate living arrangements have been communicated to the complainant; and
- ***b.*** Such social activities and socialization counselling and support services as may be suitable for the complainant and their interests are communicated to the complainant.

Response:

1. Vancouver Coastal Health confirmed that the services recommended by the board were provided to the client. These recommendations are part of routine and current practice expected of all clinicians in an interdisciplinary team caring for complex clients.

5. COMPLAINT REGARDING THE ACCURACY OF HOSPITAL MEDICAL RECORDS.

Recommendations:

1. The board recommended that the health authority should advise the complainant if the original records still exist and if so, how they can obtain access to copies of these original records in order to provide them to a family physician, psychiatrist or psychologist who could then interpret the diagnosis for the complainant.
2. The board recommended that the health authority need not respond to the complainant's request for further changes or additions concerning psychiatric issues in the hospital recordunless the complainant provides the hospital with a written opinion from a duly qualified mental health professional who has met with the complainant, reviewed the hospital file and assessed whether they have the mental illness mentioned in the psychiatric notes and comments in the hospital records. If such a report is provided, the hospital should include it in the complainant's medical file with an indication that the psychiatric report should be read together with the psychiatric notes the complainant has identified are a concern.

Response:

1. The complainant received a copy of these records. The Patient Care Quality Office has advised the client that primary documents as defined in the Hospital Act Regulations are available concerning the complainant's stays, and has provided instructions on how to request another copy of those records.
2. If the complainant brings forward additional information, the health authority will include it in the record so it is available to anyone accessing the chart.

6. COMPLAINT REGARDING THE ACCURACY OF A DISCHARGE SUMMARY.

Recommendations:

1. The board recommended that the health authority have the Patient Care Quality Office review and consider the board's findings and reasons and, to the extent that the health authority agrees with these findings, include a note of that as an addendum to the complainant's discharge summary.

Response:

1. Vancouver Coastal Health believes that the documentation already appended to the patient's chart best communicates to providers the complainant's concerns with the discharge summary, and that there would be no benefit for further comments to be appended to the chart.

7. COMPLAINT REGARDING THE USE OF MEDICATION, RESTRAINTS AND INVOLUNTARY ADMISSION IN AN EMERGENCY DEPARTMENT, AS WELL AS THE TIMELINESS OF THE PATIENT CARE QUALITY OFFICE RESPONSE.

Recommendations:

1. The board recommended that the health authority provide further mental health outreach contact information to the complainant so that the medications prescribed, use of restraints in the emergency department and the complainant's experience can be fully discussed.
2. The board recommended that the health authority review their staffing of the Patient Care Quality Office operations to ensure sufficient resources are consistently available to respond to complaint files in a timely manner, across the health authority.

Response:

1. Vancouver Coastal Health extended an offer to the client to speak to review any concerns regarding their care.
2. The Patient Care Quality Office continues to strive to manage and monitor workload and allocate resources appropriately. The Patient Care Quality Office clarified absence protocols, and implemented additional time management and task tracking processes to improve the timeliness of responses.

8. COMPLAINT REGARDING THE LACK OF COMMUNICATION ABOUT THE LEVEL OF CARE AND INTERVENTIONS PROVIDED WITH A DO NOT ATTEMPT RESUSCITATION (DNAR) CODE STATUS.

Recommendations:

1. The board recommended that the health authority conduct a review of the DNAR policy and the consent process used with a view of improving communication and understanding by patients and their families to ensure that:
   - ***a.*** patients and their families are provided with a clear explanation of the DNAR status and the levels of care and intervention provided within varying levels;
   - ***b.*** physicians on the ward who provide care to a patient admitted from the emergency department are encouraged to not make assumptions as to DNAR form filled in by the emergency department without first considering whether to review DNAR with the patient and family;
   - ***c.*** patients and their families are provided the opportunity to review the DNAR status with the most responsible physician following a reasonable period of time since the last DNAR was obtained; when a patient is transferred to a ward; when acuity levels change or whenever the family requests a review.

Recommendations(continued):

2. The board recommended that the health authority have the physician most responsible for the patient's care provide the complainant with:
   - ***a.*** an explanation regarding the similarities in the risks associated with pureed food and solid food,
   - ***b.*** an explanation of the differences between aspiration and choking; and
   - ***c.*** an explanation that resuscitation attempts exist on a spectrum from first aid through aggressive medical intervention, to heroic measures (intubation and respirator).
   - ***d.*** an explanation of all efforts undertaken following the patient's aspiration event; including that aggressive bedside attempts were promptly and correctly done; and that the next levels of intervention would likely have progressed to intubation, which the family had already indicated was a level too heroic and would have only prolonged death.

Response:

1. Based on this case, the health authority created a Quality and Safety Learning summary to include in its ongoing education about options for care and medical order for scope of treatment at Vancouver Coastal Health. The case illustrates the critical importance of clear communication and engagement with patients and families, particularly with respect to goals of care communication.
2. Vancouver Coastal Health extended an invitation to the complainant stating that the Patient Care Quality Office would be pleased to assist in the event the complainant would like a further review of the patient's care.

9. COMPLAINT REGARDING THE LOSS OF BELONGINGS WHILE IN HOSPITAL.

Recommendations:

1. The board recommended that the health authority reconsider its position and provide an explanation to the complainant regarding the loss of his belongings and what remedies they have put in place to ensure such events do not recur.
2. The board recommended that the health authority have hospital staff review this matter and the current methodology for securing personal possessions in the emergency department and determine how to improve it. The review should include the following:
   - ***a.*** How emergency department staff inform patients who are admitted to the emergency department and are able to care for their own possessions that the hospital will not be responsible for their belongings;
   - ***b.*** How patients who are unable to care for their belongings that the emergency department staff will ensure responsibility for the belongings, and how it will be documented;
   - ***c.*** Legal opinion regarding the hospital's responsibility to care for patient's belongings while they are mentally incapacitated.

Response:

1. Vancouver Coastal Health and Providence Health Care considered their positions on the matter of responsibility for personal effects of patients who are able to manage those personal effects. The Patient Care Quality Office and the emergency department leadership committed to working on signage and revised documentation to remind patients of this responsibility.
2. The Patient Care Quality Office and the emergency department leadership committed to working on signage and revised documentation to remind patients of the responsibility for capable patients to manage their belongings.

   Emergency department teams are concerned primarily with safe and timely care for patients. The Patient Care Quality Office committed to supporting emergency department leadership in a review of best practices to explore whether any process improvements are possible concerning patients who are unable to care for their belongings.

   Vancouver Coastal Health and Providence Health Care accept responsibility for safe handling of items taken into their custody and control in support of patients who are unable to care for their belongings. They rely on health-care providers to apply their clinical judgement in making that determination. Vancouver Coastal Health and Providence Health Care accept that a legal determination of correctness of that judgement will be a based on the particular facts of any claim.

10. COMPLAINT REGARDING DELAYED SURGERY, POOR CHARTING AND SEPSIS PROTOCOLS RESULTING IN DEATH.

Recommendations:

1. The board recommended that the health authority have an expert in emergency department medicine and an expert in surgical services conduct a second quality assurance review on the care provided to this patient. Any recommendations resulting from the review should be shared with the complainant along with the plan for implementing and sustaining them.
2. The board recommended that the health authority follow-up with the complainant to explain the course of care and treatment received by the patient in the facility and explain the cause of death and inform the complainant what is being done to improve subsequent care at the facility.

Response:

1. Vancouver Coastal Health committed to planning a quality assurance review of the patient's care with experts in emergency medicine, nursing and general surgery.
2. Vancouver Coastal Health extended an invitation to the complainant to meet to review the outcome of the review.

11. COMPLAINT REGARDING THE PREMATURE FAILURE OF LINERS USED IN A HIP REPLACEMENT.

Recommendations:

1. The board recommended that the health authority provide the complainant with instructions on how to access medical records and facilitate, if the complainant chooses, a review from an orthopedic surgeon in regards to failure of his hip replacements.

Response:

1. The Patient Care Quality Office already facilitated the provision of the patient's medical records for both surgeries. Should the complainant wish an additional copy of the records, the Patient Care Quality Office will provide the complainant with another copy of the health records request forms for use.

   Experts contacted by the Patient Care Quality Office have advised that the question concerning the reason for failure of the specific hip replacement liners is not a question that can be answered, and may in fact not even have been able to be determined through analysis of the original hip replacement liners. The liners were surgically removed and are no longer available for analysis. The Patient Care Quality Office has communicated this to the patient. Vancouver Coastal Health does not consider any merit in pursuing an additional review by an orthopedic surgeon.

12. COMPLAINT REGARDING CARE IN HOSPITAL FOLLOWING AN ISOLATION PROTOCOL.

Recommendations:

1. The board recommended that the health authority review this case to consider strategies designed to better support the social needs of patients restricted to isolation rooms.

Response:

1. Vancouver Coastal Health committed to revise the clinical practice documents concerning isolation to prompt staff to consider and attend to the social needs of patients restricted to isolation rooms. As well, the health authority will revise patient education materials so patients who have any concerns about being in isolation are encouraged to raise those concerns with their care teams.

13. COMPLAINT REGARDING THE TRANSFER AND DISCHARGE OF A PATIENT BETWEEN ACUTE CARE FACILITIES.

Recommendations:

1. The board recommended that the health authority ensure that transferring hospitals maintain an appropriate charting record of what documentation is transferred to the receiving hospital with the patient.
2. The board recommended that the health authority review its patient transfer and discharge practices.
3. The board recommended that the health authority have the chief of medical staff review complex care medical discharge procedures to develop a protocol with a view to ensure that:
   a. discharges are understandable and properly communicated to families;
   b. discharges cover foreseeable events in the patient's recovery, and spell out what the patient and their family are to do in the event of reasonably foreseeable possible relapses and complications; and
   c. discharges provide a procedure where recently released patients can return to the hospital they were discharged from if complications or relapse occur and specialized care is once again indicated.

Response:

1. Vancouver Coastal Health established a region-wide patient flow working group to explore and improve various aspects of patient flow including transfers, and directed that group to explore an approach to maintaining a record of what documentation is transferred to the receiving hospital with the patient.
2. A key objective of the region-wide patient flow working group is the review and improvement of patient transfer and discharge practices.
3. The region-wide patient flow working group committed to consider the implementation of the 'My Discharge Plan' communication tool, which is a written summary of discharge information that is reviewed with the patient at discharge and provided as a take-home resource, across Vancouver Coastal.

   As part of the discharge planning process, Vancouver Coastal Health expects providers and patients to be clear on foreseeable concerns and have strategies in place to address them. For their own safety, patients experiencing urgent need for care should receive that care at the closest setting and, if necessary, be transferred to a higher level of care once stabilized.

   For optimal patient care and access, Vancouver Coastal Health committed to working with their partners across the province on a memorandum of understanding concerning repatriation of patients to provide a framework for patient transfers between agencies.

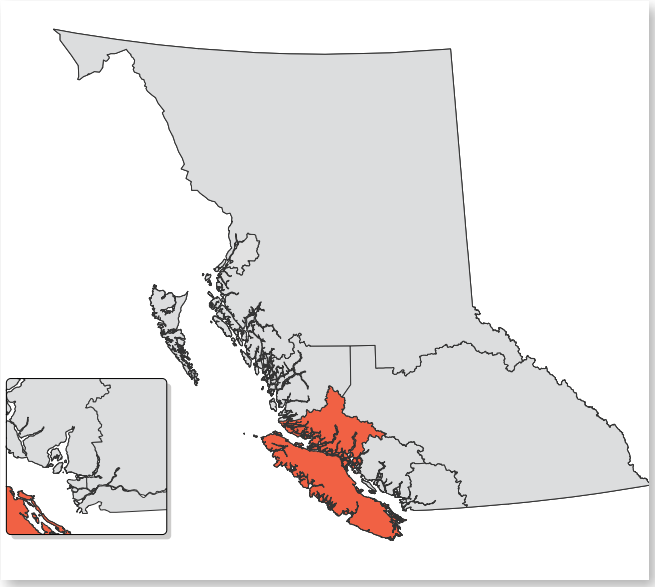
CASE STUDY | Emergency

Following a car accident, a patient was admitted to an emergency department with two broken teeth. The emergency department physician reinserted his teeth, gave him pain medication and discharged him home with instructions to see a dentist.

The patient saw a dentist the next day and was immediately referred to an oral surgeon. The oral surgeon stated that he was surprised that the hospital did not have a dentist on call, who could have treated his condition immediately. Due to the time that had lapsed, the patient was required to have surgery for shifted teeth and would need braces. When the patient recovered, he raised his concerns with the health authority's Patient Care Quality Office. Not satisfied with the health authority's response, the patient requested a review by the board.

The board recommended that the heath authority have a dental injury specialist do a thorough examination of the emergency department process to make sure patients with dental injuries receive appropriate, timely care. The board also recommended that the health authority request the College of Dental Surgeons of B.C. provide them with a list of dentists in the hospital area who would be willing to provide 24-hour emergency dental care.

As a result of the board's recommendations, the health authority committed to working with a dental injury specialist to review the current process in the emergency department. Also, the health authority requested a list of dentists from the college.



Island Health is responsible for more than 765,000 people, spread over the islands and the mainland.

The board reviewed eight cases from Island Health in 2015/16, resulting in four recommendations in three of those cases. All four recommendations were for care quality improvement. The board made no recommendations in five cases.

The board's recommendation related to personnel that may be required to be present during surgery, training related to dementia, and intake and discharge procedures at a pain clinic.

1. COMPLAINT REGARDING UNNECESSARY SURGERY, AND NON-HEALTH AUTHORITY STAFF BEING PRESENT DURING THE SURGERY.

Recommendations:

1. The board recommended that the health authority review their current consent documents and amend them so they reflect all possible personnel that may be required to be present during surgery.

Response:

1. The health authority advised that Section 4 of the Consent for Surgical and/or Special Procedures form, which reads, "I agree that the doctor/provider named above may use the help of other surgeons, doctors, medical residents, authorized students and hospital staff," will be updated to include industry representatives.

2. COMPLAINT REGARDING THE CARE AND USE OF RESTRAINTS IN A HOSPITAL.

Recommendations:

1. The board recommended that the health authority consider having all front-line staff who work with dementia patients be given additional in-service module training on;
   - ***a.*** Working with dementia patients;
   - ***b.*** The effective use of restraints;
   - ***c.*** The hospital policies covering the use of restraints; and
   - ***d.*** Maintaining the dignity of patients while in restraints.
2. The board recommended that the health authority review the staffing levels in this ward and determine whether the current levels are meeting the needs of patients, with particular focus on appropriate patient/staff load levels, time for appropriate charting and patient safety. If changes are made, the health authority should complete an audit six months from the implementation.

Response:

1. All medicine floors at the hospital have been working on a dementia project, which focuses on the improved care and safety of dementia patients while in hospital. All staff on the unit are participating in learning and education, which includes working within health authority policies and procedures regarding the use of restraints and safe patient care. This will be an ongoing process for the hospital to use when it comes to care of dementia patients.
2. Local leadership has examined, and will continue to evaluate, the care model/staffing levels on all inpatient units at the hospital. For this particular unit, health care aide levels have stabilized to provide more consistent care to those patients in need of dementia care. As well, a registered nurse has been added to the team after the BC Nurses Union and health authority reached a collaborative post-sufficing agreement. There will be no further changes to the provider mix in the coming months. However, leadership will conduct an audit to make sure staffing levels are meeting the needs of the patients.

3. COMPLAINT REGARDING CARE AND DISCHARGE FROM A HOSPITAL AFTER AN OUTPATIENT PROCEDURE.

Recommendations:

1. The board recommended that the health authority conduct a comprehensive review of the intake and discharge procedures at the [hospital] pain clinic including:
   - ***a.*** Assessment of the intake questionnaire to ensure that the questions and the information provided by patients in the answers are valuable and form the basis of their treatment, and discharge planning.
   - ***b.*** A review by staff of the pain program questionnaire and pain program record at the time of discharge, to ensure an appropriate physical and cognitive assessment has been completed.
   - ***c.*** Inclusion in the discharge instructions of information for the patient so that they know that they may present to an emergency department or call 911 should pain continue.

Response:

1. A comprehensive review of the intake and discharge procedures at the hospital's pain clinic was conducted by the director, manager and clinical nurse educator. The manager and clinical nurse educator committed to review documentation standards at an upcoming team meeting to make sure the information gathered is succinct, applicable and actionable.

An assessment of the intake questionnaire indicated that the questions and answers provided by patients were valuable in informing discharge planning. However, as noted above, the manager and clinical nurse educator will review documentation standards at an upcoming team meeting. Upon review, it was felt the pain program questionnaire and pain program record provides an appropriate physical and cognitive assessment. There is a section on the bottom of the pain program record for post procedure and discharge notations. As noted, a review of documentation standards will be undertaken with staff.

Island Health appreciates input from patients with respect to the forms. Island Health's Patient Advisory Council is a valued resource for providing the patient's perspective, and in light of the concerns raised by the complainant, the advisory council will be asked to review the forms noted by the board to determine if additional changes not identified by staff are required.

Changes were made to the discharge instructions: "call 911" was added to the form and the new form was implemented in April 2016.

Appendix A | *Patient Care Quality Office Volumes*

Appendix A details the volume of all complaints and inquiries received by the health authority Patient Care Quality Offices in 2015/2016. It compares the top five issues, or subjects of complaint, within the province and each health authority for 2011/12, 2012/13, 2013/14, 2014/2015 and 2015/2016.[2]

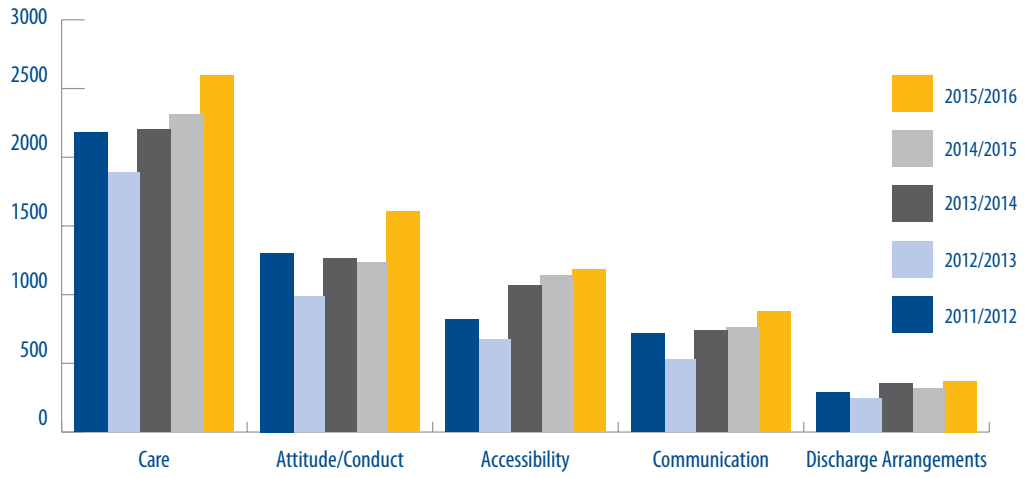
British Columbia

TABLE 3: *Patient Care Quality Office Volume, B.C., 2015/16*

B.C.	APR-JUNE 2015	JULY-SEPT 2015	OCT-DEC 2015	JAN-MAR 2016	TOTAL
External Complaints	45	55	45	99	244
Care Quality Complaints	1865	1764	1660	1844	7133
Inquiries	410	392	401	316	1519
TOTAL VOLUME	**2320**	**2211**	**2106**	**2259**	**8896**

By definition, most care quality concerns relate to care (e.g., deficiencies in care, misdiagnosis or medication-related concerns). Therefore, complaints tend to be concentrated in that category. In B.C., Patient Care Quality Offices logged 2,594 complaints related to care. Attitude and conduct followed with 1,604 complaints. Accessibility (e.g., wait times for surgery or test results, availability of services) was the third most frequently reported issue at 1,180. Communication was fourth at 878, followed by discharge arrangements at 372.

CHART 4: *Patient Care Quality Office Top 5 Subjects, B.C., 2015/16*



2 The Patient Care Quality Offices categorize patient complaints using a common reporting framework. Complaints are first categorized according to health sector – including acute care, ambulatory care, emergency care, home and community care, mental health and addictions, residential care, and public health, among others – then further broken down by subject. We have reported the top five subjects across sectors illustrating the key concerns patients bring to their offices. Note: One complaint typically encompasses more than one care issue, so the total number of care issues will generally be higher than the total number of complaints.

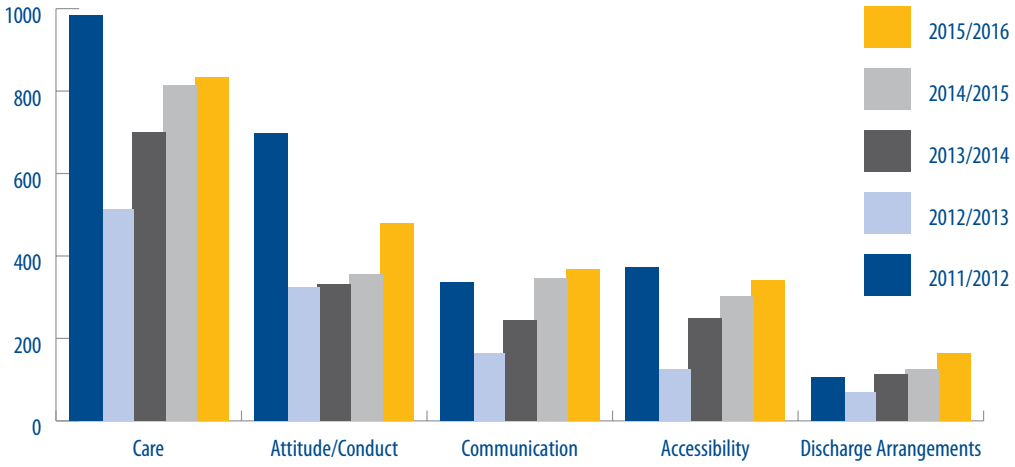
Fraser Health

TABLE 4: *Patient Care Quality Office Volume, Fraser Health, 2015/16*

FRASER HEALTH	APR-JUNE 2015	JULY-SEPT 2015	OCT-DEC 2015	JAN-MAR 2016	TOTAL
External Complaints	22	22	17	32	93
Care Quality Complaints	463	450	419	470	1802
Inquiries	99	84	93	96	372
TOTAL VOLUME	**584**	**556**	**529**	**598**	**2267**

Fraser Health logged 814 complaints in the care category, which represents an increase of 115 over 2013/14. Attitude and conduct was the second most frequently reported concern with 356 complaints, followed by communication at 346 and accessibility at 301. Discharge arrangement complaints totalled 126 for the year. Four of the five categories saw an increase in complaints from 2013/14.

CHART 5: *Patient Care Quality Office Top Five Subjects, Fraser Health, 2015/16*



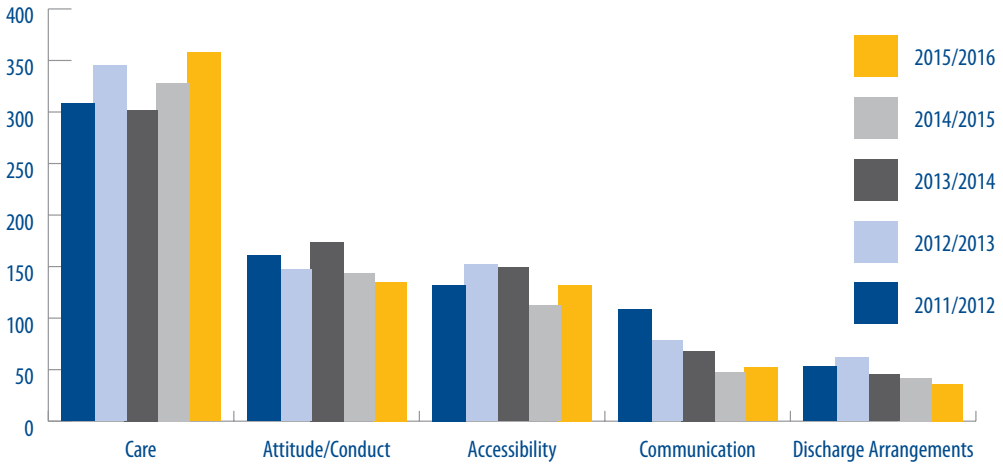
Interior Health

TABLE 5: *Patient Care Quality Office Volume, Interior Health, 2015/16*

INTERIOR HEALTH	APR-JUNE 2015	JULY-SEPT 2015	OCT-DEC 2015	JAN-MAR 2016	TOTAL
External Complaints	5	12	3	22	42
Care Quality Complaints	285	261	268	298	1112
Inquiries	40	31	40	23	134
TOTAL VOLUME	**330**	**304**	**311**	**343**	**1288**

Interior Health logged 358 complaints in the care category, which represents an increase of 30 from last year. Attitude and conduct was the second most frequently reported concern with 135 complaints. Accessibility was third with 132 complaints, followed by communication at 52 and discharge arrangements with 36 complaints.

CHART 6: *Patient Care Quality Office Top Five Subjects, Interior Health, 2015/16*



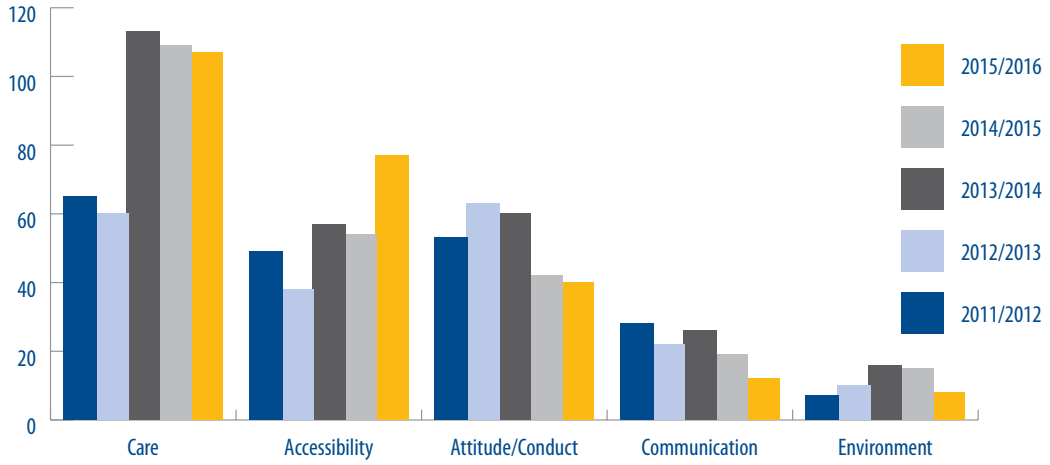
Northern Health

TABLE 6: *Patient Care Quality Office Volume, Northern Health, 2015/16*

NORTHERN HEALTH	APR-JUNE 2015	JULY-SEPT 2015	OCT-DEC 2015	JAN-MAR 2016	TOTAL
External Complaints	14	4	8	10	36
Care Quality Complaints	82	89	78	82	331
Inquiries	42	22	15	16	95
TOTAL VOLUME	**138**	**115**	**101**	**108**	**462**

Northern Health logged 107 complaints in their care category, down only slightly from last year's total of 109. Complaints about accessibility were the next most frequently reported concern at 77, which was 23 more than 2014/2015. Complaints about attitude and conduct were at 40. Communication accounted for 12 complaints, while environment concerns were logged on eight occasions. While the geographic area is large, Northern Health serves a smaller population relative to the other health authorities. As such, the smaller population may explain the lower volumes of care quality complaints.

CHART 7: *Patient Care Quality Office Top Five Subjects, Northern Health, 2015/16*



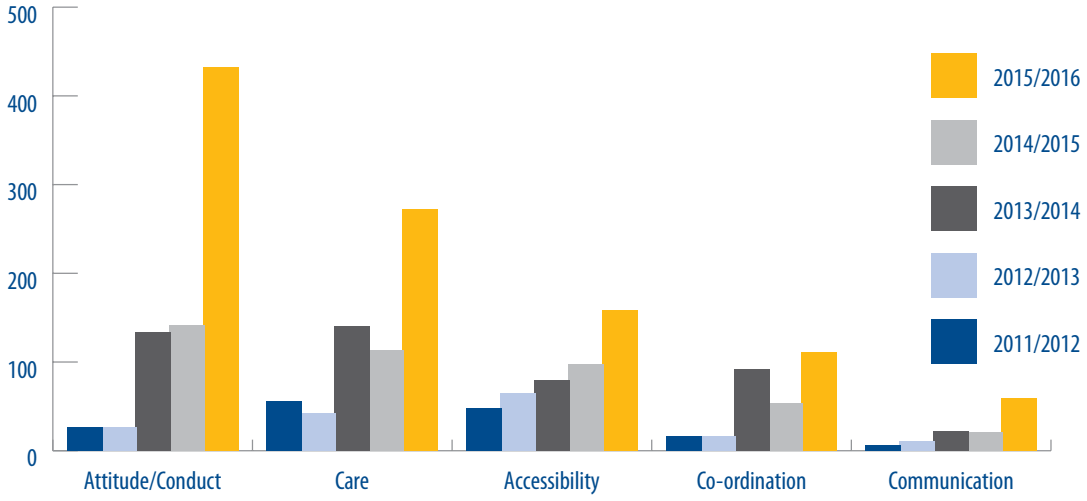
Provincial Health Services Authority

TABLE 7: *Patient Care Quality Office Volume, Provincial Health Services Authority, 2015/16*

PHSA	APR-JUNE 2015	JULY-SEPT 2015	OCT-DEC 2015	JAN-MAR 2016	TOTAL
External Complaints	2	8	6	9	25
Care Quality Complaints	140	158	173	175	646
Inquiries	124	132	124	71	451
TOTAL VOLUME	**266**	**298**	**303**	**255**	**1122**

This year, the Provincial Health Services Authority logged 432 complaints about attitude and conduct, which was significantly higher than last year's total of 141. Care was the second most frequently reported care quality complaint at 272, which was also significantly higher than last year's total of 113. Accessibility followed at 158. Co-ordination was fourth with 111 complaints, and communication fifth with 59. All five categories showed a significant increase in complaints compared to previous years.

CHART 8: *Patient Care Quality Office Top Five Subjects, Provincial Health Services Authority, 2015/16*



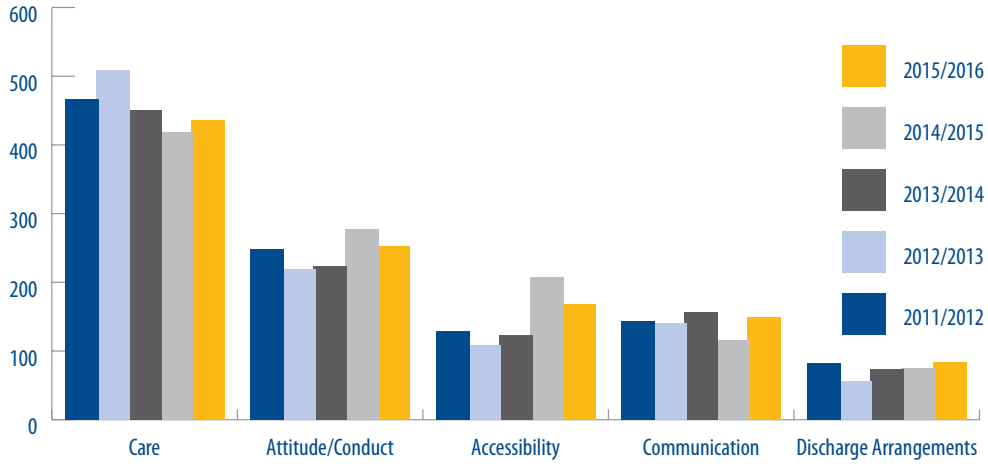
Vancouver Coastal Health

TABLE 8: *Patient Care Quality Office Volume, Vancouver Coastal Health, 2015/16*

Vancouver Coastal Health	APR-JUNE 2015	JULY-SEPT 2015	OCT-DEC 2015	JAN-MAR 2016	TOTAL
External Complaints	2	6	7	9	24
Care Quality Complaints	457	403	344	375	1579
Inquiries	57	55	50	50	212
TOTAL VOLUME	**516**	**464**	**401**	**434**	**1815**

Vancouver Coastal Health logged 436 complaints in the care category, an increase of 17 from 2015/2016. Attitude and conduct followed at 252. Accessibility was at 168, down from 207 last year, while communication complaints increased from 115 to 149. Discharge arrangements complaints came in fifth at 83.

CHART 9: *Patient Care Quality Office Top Five Subjects, Vancouver Coastal Health, 2015/16*



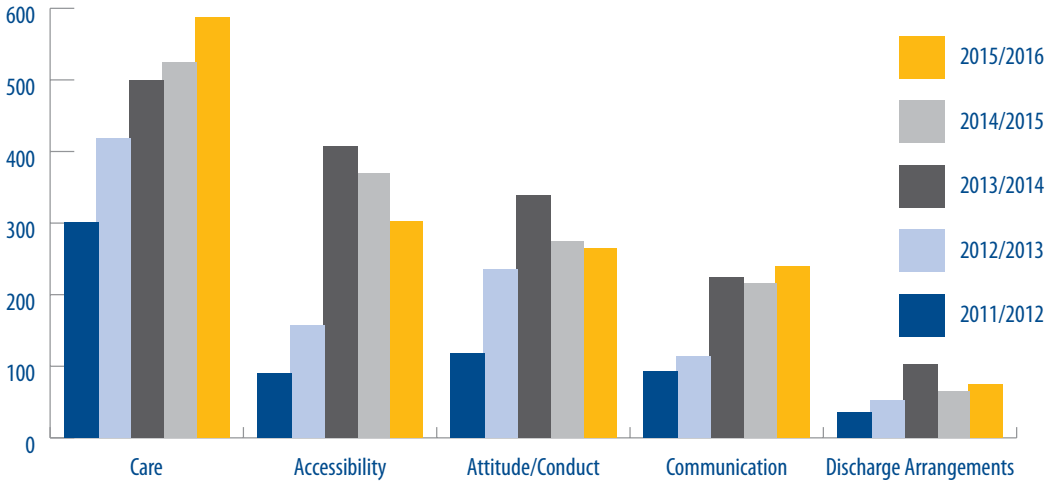
Island Health

TABLE 9: *Patient Care Quality Office Volume, Island Health, 2015/16*

VANCOUVER COASTAL HEALTH	APR-JUNE 2015	JULY-SEPT 2015	OCT-DEC 2015	JAN-MAR 2016	TOTAL
External Complaints	0	3	4	17	24
Care Quality Complaints	438	403	378	444	1663
Inquiries	48	68	79	60	255
TOTAL VOLUME	**486**	**474**	**461**	**521**	**1942**

Island Health logged 588 concerns in the care category, an increase of 63 from 2015/2016. Accessibility complaints were down to 303 from 369. Attitude and Conduct complaints fell slightly from 275 down to 265 in 2015/2016. Communication complaints stayed at much the same level with 239 complaints. Finally, Island Health logged 75 complaints about discharge arrangements.

CHART 10: *Patient Care Quality Office Top Five Subjects, Vancouver Coastal Health, 2015/16*



Appendix B | *Financial Information*

(Source: Corporate Accounting Services Financial Reports)

EXPENDITURES	ACTUAL $ 2015/16
Board Members	
Board Meeting fees and expenses	$155,797.48
TOTAL	**$155,797.48**
Board Support	
Board Support Personnel	$1,086,544.78
Board Support Travel	$21,594.00
Legal Expenses and Professional Services	$11,720.49
Office Business and Info Systems	$24,511.03
TOTAL	**$1,144,370.30**
TOTAL EXPENDITURES	**$1,300,167.78**

Further Information

Patient Care Quality Review Board Act

A copy of the *Patient Care Quality Review Board Act* may be obtained from *www.patientcarequalityreviewboard.ca* or by calling BC Laws toll-free at 1 800 663-6105.

Patient Care Quality Review Boards

For more information about whe Patient Care Quality Review Boards or to request a review, please contact:

Patient Care Quality Review Boards
PO Box 9643, Victoria, BC V8W 9P1
Toll-free: 1 866 952-2448
Fax: 250 952-2428
Email: *contact@patientcarequalityreviewboard.ca*

Patient Care Quality Office

To make a complaint regarding the quality of care that you or a loved one received, please contact the health authority Patient Care Quality Office in your region:

Fraser Health

11762 Laity St, 4th floor, Maple Ridge, BC V2X 5A3
Phone: 877 880-8823 (toll-free)
Fax: 604 463-1888
Email: *pcqoffice@fraserhealth.ca*
Website: *www.fraserhealth.ca*

Interior Health

505 Doyle Ave, Kelowna, BC V1Y 0C5
Phone: 1-877-442-2001 (toll-free)
Fax: 250-870-4670
Email: *patient.concerns@interiorhealth.ca*
Website: *www.interiorhealth.ca*

Island Health

Royal Jubilee Hospital, Memorial Pavilion, Watson Wing,
Rm 315, 1952 Bay Street, Victoria, BC V8R 1J8
Phone: 1 877 977-5797 (toll-free)
Fax: 250 370-8137
Email: *patientcarequalityoffice@viha.ca*
Website: *www.viha.ca*

Northern Health

6th floor, 299 Victoria Street, Prince George, BC V2L 5B8
Phone: 1 877 677-7715 (toll-free)
Fax: 250 565-2640
Email: *patientcarequalityoffice@northernhealth.ca*
Website: *www.northernhealth.ca*

Provincial Health Services Authority

(Includes provincial agencies and services such as BC Cancer Agency, BC Renal Agency, BC Transplant, BC Emergency Health Services, and BC Women's and Children's Hospital)

Suite 202, 601 West Broadway Street,
Vancouver BC V4Z 4C2
Phone: 1 888 875-3256 (toll-free)
Fax: 604 829-2631
Email: *pcqo@phsa.ca*
Website: *www.phsa.ca*

Vancouver Coastal Health

855 West 12th Avenue, CP-117,
Vancouver, BC V5Z 1M9
Phone: 1 877 993-9199 (toll-free)
Fax: 604 875-5545
Email: *pcqo@vch.ca*
Website: *www.vch.ca*

BRITISH COLUMBIA

Patient Care Quality Review Boards